COMMONWEALTH OF VIRGINIA
2003 Health Benefits Plans RFPs OHB03-2, 3, 4 , and 5

This *Attachment 1* to the subject RFPs consists of the following:

1. A. Summary Chart of Current COVA Care Benefits

1. B. Summary Chart of Current TLC Benefits

1. C. Blank Summary Chart

As directed in paragraph 6.2 of the RFPs, these charts must be submitted as Tab 2 of a proposal.

If your proposed benefits are identical to the current plans, a brief annotation to that effect on Attachments 1. A. and 1. B. is required.

If the proposed benefits vary to some degree, but resemble the current program (e.g., different deductibles), submit an MS Word redline edit version of Attachments 1. A. and 1.B.

If your proposed benefits are materially different than the current programs, complete and submit an attachment 1. C. for each plan of benefits proposed.

COVA CARE BASIC SCHEDULE OF BENEFITS *Attachment 1 A*

	Individual	Family
Calendar Year Deductible:	$200	$400
Annual Out-of-Pocket Limits	$1500	$3000
Lifetime Maximum *(Other Covered Services)*	$1,500,000	

Basic Benefits	**Co-Payment**	**Deductible Applies?**	**In-network Coinsurance**	**Comments:**
Accidental Dental Injuries	$0	Yes	20%	
Ambulance Travel	$0	Yes	20%	No Calendar Year Limit
Diagnostic test and x-rays				
• Inpatient	$0	No	0%	
• Outpatient, including Office	$0	Yes	10%	
Doctor's Visits				
Inpatient				
• Primary Care Physician (PCP)	$0	No	0%	
• Specialist	$0	No	0%	
Outpatient /Office				
• Primary Care Physician (PCP)	$25	No	0%	
• Specialist	$35	No	0%	
Home Health Care	$0	No	0%	90-visit Calendar Year Limit
Hospice Care Services	$0	No	0%	
Hospital Services				
• Inpatient Facility	$300 per stay	No	0%	
• Outpatient Facility,incl.ER visits	$100 per visit	No	0%	Waived if admitted
Mental Health or Substance Abuse Treatment				
Inpatient Treatment				
• Facility	$300 per stay	No	0%	
• Professional Provider Services	$0	No	0%	
Partial Day Program	$300 per stay	No	0%	
Outpatient Treatment				
• Facility Services	$100	No	0%	
• Specialist	$35	No	0%	
Employee Assistance Program	$0	No	0%	Four visits per incident
Medical Equipment, appliances and supplies	$0	Yes	20%	Includes Diabetic Supplies
Nursing Services – Private Duty	$0	Yes	20%	Home Services only
Oral Surgery	$ 35	No	0%	
Skilled Nursing Facility				
• Facility	$0 per stay	No	0%	180 day per stay limit
• Professional Provider Services	$0	No	0%	
Surgery				
Inpatient				
• PCP/Specialist	$0	No	0%	
• Assistant Surgeon	$0	No	0%	Medical Necessity Review
• Anesthesiologist	$0	No	0%	Medical Necessity Review
Outpatient				
• PCP	$25	No	0%	
• Specialist	$35	No	0%	
• Anesthesiologist	$35	No	0%	Medical Necessity Review
Wellness Services				
Well child - Office Visits at specified intervals through age 6 (Includes all immunizations given at the time of the Office Visit)				
• PCP	$25	No	0%	
• Specialist	$35	No	0%	
Screening Tests	$0	No	10%	
Routine Wellness/Preventative care (Age 7 and older)				

Annual check-up				
• PCP	$25	No	0%	
• Specialist	$35	No	0%	
Immunizations	$0	No	10%	Plan pays 90% coinsurance up to a $200 CY maximum.
Lab and x-ray services	$0	No	10%	
Preventative Care				
Annual gynecological exam				
• PCP	$25	No	0%	
• Specialist	$35	No	0%	
Annual Pap test	$0	No	10%	
Annual mammography screening, beginning at age 35	$0	No	10%	
Annual Prostate exam (digital rectal exam), beginning at age 40				
• PCP	$25	No	0%	
• Specialist	$35	No	0%	
Annual Prostate specific antigen test, beginning at age 40	$0	No	10%	
Colorectal cancer screening	$0	No	10%	
Prescription Drugs				
Retail pharmacy (per 34 day supply)				
• First Tier	$15	No	0%	Typically generic drugs
• Second Tier	$20	No	0%	Lower cost brand-name drugs
• Third Tier	$35	No	0%	Higher cost brand-name drugs
Mail Order (up to 90 day supply)				
• First Tier	$30	No	0%	Typically generic drugs
• Second Tier	$40	No	0%	Lower cost brand-name drugs
• Third Tier	$70	No	0%	Higher cost brand-name drugs
Dental Services – The Basic Plan includes most services except prosthetic, complex restorative and orthodontic. Covered expenses are not subject to a deductible and limited to a $1200 calendar year maximum				
• Diagnostic/Preventative Services	$0	No	0%	
• Primary Services	$0	No	20%	
Optional Benefits – These benefits can be purchased at an additional cost to supplement the Basic Plan.				
Out-of Network Option	25% penalty applied to the eligible benefit.			
Expanded Dental	The annual Dental maximum increases from $1200 to $1500 with this option			
• Prosthetic and Complex Restorative	$0	No	50%	
• Orthodontic	$0	No	50%	Lifetime maximum $1200
Vision/Hearing/Expanded Dental				
Vision – benefits are limited to once every 24 months				
• Eye Exam	$35	No	0%	
• Frames	$75 benefit maximum			
• Lenses				
o Single Vision	$50 benefit maximum			
o Bifocal	$75 benefit maximum			
o Trifocal	$100 benefit maximum			
o Contacts	$100 in lieu of eyeglass lenses			
Hearing – benefits are limited to once every 48 months				
• Exam	$35	No	0%	
Hearing Aid(s) & related services		$1200 benefit maximum		
Expanded Dental – same as above				

The Local Choice Schedule of Benefits *Attachment 1 B*

Key Advantage -25% Penalty applies to out of network providers except for emergency services

	Individual	Family
Calendar Year Major Medical Deductible:	$100	$400
Annual Out-of-Pocket Limits	$1000	$3000
Lifetime Maximum *(Major Medical Services)*	$1,000,000	

	Co-Payment	**Deductible Applies?**	**Coinsurance**	**Comments:**
Accidental Dental Injuries	$0	Yes	20%	Under MM
Ambulance Travel	$0	Yes	20%	
Diagnostic test and x-rays				
• Inpatient	$200/confinement	No	0%	
• Outpatient/ Office	$0	No	10%	
Doctor's Visits				
Inpatient				
• Primary Care Physician (PCP)	$0	No	0%	
• Specialist	$0	No	0%	
Outpatient /Office				
• Primary Care Physician (PCP)	$15	No	0%	
• Specialist	$25	No	0%	
Home Health Care	$15 PCP/$25 Specialist	No	0%	90-visit CY Limit
Hospice Care Services	$15 PCP/$25 Specialist	No	0%	
Hospital Services				
• Inpatient Facility	$200/confinement	No	0%	
• Outpatient Facility, incl. ER visits	$75 per visit	No	0%	Waived if admitted
Mental Health or Substance Abuse Treatment				
Inpatient Treatment				
• Facility	$200 /confinement	No	0%	
• Professional Provider Services	$0	No	0%	
Partial Day Program	$200 /confinement	No	0%	
Outpatient Treatment				
• Facility Services	$75	No	0%	Waived if admitted
• Specialist	$25	No	0%	
Employee Assistance Program	$0	No	0%	Four visits/ incident
Nursing Services – Private Duty	$0	Yes	20%	
Skilled Nursing Facility				
• Facility	$0 per stay	No	0%	180 day limit
• Professional Provider Services	$0	No	0%	
Surgery				
Inpatient				
• PCP/Specialist	$0	No	0%	
• Assistant Surgeon	$0	No	0%	Medical Necessity Review
• Anesthesiologist	$0	No	0%	Medical Necessity Review
Outpatient				
• PCP	$15	No	0%	
• Specialist incl. Anesthesiologist	$25	No	0%	

The Local Choice Schedule of Benefits ***Attachment 1 B***

Prescription Drugs				
Retail pharmacy (per 34 day supply)				
• First Tier	$15	No	0%	Typically generic drugs
• Second Tier	$20	No	0%	Lower cost brand-name drugs
• Third Tier	$35	No	0%	Higher cost brand-name drugs
Mail Order (up to 90 day supply)				
• First Tier	$18	No	0%	Typically generic drugs
• Second Tier	$33	No	0%	Lower cost brand-name drugs
• Third Tier	$63	No	0%	Higher cost brand-name drugs
Dental Services – The Basic Plan includes most services except prosthetic, complex restorative and orthodontic. Covered expenses are not subject to a deductible and limited to a $1200 calendar year maximum				
• Diagnostic/Preventative Services	$0	No	0%	
• Primary Services	$0	No	20%	
Optional Benefits – These benefits can be purchased by the employer at an additional cost to supplement the Basic Plan.				
Expanded Dental				
• Prosthetic and Complex Restorative	$0	No	50%	
• Orthodontic	$0	No	50%	Lifetime maximum $1200
Vision				
Vision – benefits are limited to once every 24 months				
• Eye Exam	$25	No	0%	
• Frames	$75 benefit maximum			
• Lenses				
o Single Vision	$50 benefit maximum			
o Bifocal	$75 benefit maximum			
o Trifocal	$100 benefit maximum			
o Contacts	$100 in lieu of eyeglass lenses			

The Local Choice Schedule of Benefits *Attachment 1 B*

Cost Alliance - No Out of Network Benefits other than Emergency

Annual Out-of-Pocket Limits $2500 per Covered Person
Lifetime Maximum $1,000,000

	Co-Payment	Deductible Applies?	Coinsurance	Comments:
Accidental Dental Injuries	$20PCP/ $35 Specialist	N/A	N/A	Accident treatment only
Ambulance Travel	$0	N/A	N/A	A/C non-emergency pre-cert
Diagnostic test and x-rays				
• Inpatient	$100/day $500 max	N/A	N/A	A/C
• Outpatient, including Office	$20 PCP/$35 Specialist	N/A	N/A	A/C
Doctor's Visits				
Inpatient				
• Primary Care Physician (PCP)	$0	N/A	N/A	A/C
• Specialist	$0	N/A	N/A	A/C
Outpatient /Office				
• Primary Care Physician (PCP)	$20	N/A	N/A	A/C
• Specialist	$35	N/A	N/A	A/C
Home Health Care	$0	N/A	N/A	Pre-cert
Hospice Care Services	$0	N/A	N/A	A/C
Hospital Services				
• Inpatient Facility	$100/day $500 max	N/A	N/A	A/C
• Outpatient Facility, incl. ER visits	$75 per visit	N/A	N/A	Waived if admitted
Mental Health or Substance Abuse Treatment				
Inpatient Treatment				
• Facility	$100/day $500/ max	N/A	N/A	A/C
• Professional Provider Services	$0	N/A	N/A	A/C
Partial Day Program	$100/day $500/ max	N/A	N/A	A/C
Outpatient Treatment				
• Facility Services	$75 per visit	N/A	N/A	Waived if admitted
• Specialist	$35	N/A	N/A	A/C
Employee Assistance Program	$0	N/A	N/A	Four visits per incident
Nursing Services – Private Duty	N/A	N/A	N/A	
Skilled Nursing Facility				
• Facility	$0	N/A	N/A	100 day per stay A/C
• Professional Provider Services	$0	N/A	N/A	A/C
Surgery				
Inpatient				
• PCP/Specialist	$0	N/A	N/A	
• Assistant Surgeon	$0	N/A	N/A	Medical Necessity Review
• Anesthesiologist	$0	N/A	N/A	Medical Necessity Review
Outpatient				
• PCP	$20	N/A	N/A	
• Specialist incl. Anesthesiologist	$35	N/A	N/A	

Prescription Drugs				
Retail pharmacy (per 34 day supply)				
• First Tier	$15	No	0%	Typically generic drugs
• Second Tier	$20	No	0%	Lower cost brand-name drugs
• Third Tier	$35	No	0%	Higher cost brand-name drugs
Mail Order (up to 90 day supply)				
• First Tier	$18	No	0%	Typically generic drugs
• Second Tier	$33	No	0%	Lower cost brand-name drugs
• Third Tier	$63	No	0%	Higher cost brand-name drugs
Dental Services –Covered expenses are not subject to a deductible and limited to a $1200 calendar year maximum				
• Diagnostic/Preventative Services	$0	No	0%	
• Primary Services	$0	No	20%	
• Prosthetic and Complex Restorative	$0	No	50%	
• Orthodontic	$0	No	50%	Lifetime maximum $1200

KeyShare -25% Penalty applies to out of network providers except for emergency services

Plan Year Deductible: $200 Per covered person Not to exceed $600 per Family
Plan Year Out-of-Pocket Limits $2000 Per covered person Not to exceed $6000 per Family

	Co-Payment	**Deductible Applies?**	**Coinsurance**	**Comments:**
Accidental Dental Injuries	$20 PCP/$30 Specialist treated in the office	Yes for IP/OP treatment	20% for IP/OP treatment	Medical Only
Ambulance Travel	$0	Yes	20%	
Diagnostic test and x-rays				
• Inpatient	$0	Yes	20%	
• Outpatient	$0	Yes	20%	
• Office	$0	Yes	20%	
Doctor's Visits				
Inpatient				
• Primary Care Physician (PCP)	$0	Yes	20%	
• Specialist	$0	Yes	20%	
Outpatient /Office				
• Primary Care Physician (PCP)	$20	No	0%	
• Specialist	$30	No	0%	
Home Health Care	$0	Yes	20%	90-visit CY Limit
Hospice Care Services	$20 PCP/$30 Specialist	No	0%	
Hospital Services				
• Inpatient Facility	$0	Yes	20%	
• Outpatient Facility, including ER visits	$0	Yes	20%	
Mental Health or Substance Abuse Treatment				
Inpatient Treatment				
• Facility	$0	Yes	20%	
• Professional Provider Services	$0	Yes	20%	
Partial Day Program	$0	Yes	20%	
Outpatient Treatment				
• Facility Services	$0	Yes	20%	
• Specialist	$30	No	0%	
Employee Assistance Program	$0	No	0%	Four visits per incident
Nursing Services – Private Duty	$0	Yes	20%	
Skilled Nursing Facility				
• Facility	$0	Yes	20%	180 day per stay limit
• Professional Provider Services	$0	Yes	20%	
Surgery				
Inpatient				
• PCP/Specialist	$0	Yes	20%	
• Assistant Surgeon	$0	Yes	20%	
• Anesthesiologist	$0	Yes	20%	
Outpatient				
• PCP	$20	Yes	20%	
• Specialist incl. Anesthesiologist	$30	Yes	20%	
Routine Wellness/Preventative care (Age 7 and older)				

Annual check-up				
• PCP	$20	No	0%	
• Specialist	$30	No	0%	
Immunizations	$0	No	20%	Plan pays 80% coinsurance up to a $150 CY maximum.
Lab and x-ray services	$0	No	20%	
Preventative Care				
Annual gynecological exam				
• PCP	$20	No	0%	
• Specialist	$30	No	0%	
Annual Pap test	$0	No	20%	
Annual mammography screening, beginning at age 35	$0	Yes	20%	
Annual Prostate exam (digital rectal exam), beginning at age 40				
• PCP	$20	No	0%	
• Specialist	$30	No	0%	
Annual Prostate specific antigen test, beginning at age 40	$0	Yes	20%	
Colorectal cancer screening	$0	Yes	20%	
Prescription Drugs				
Retail pharmacy (per 34 day supply)				
• First Tier	$15	No	0%	Typically generic drugs
• Second Tier	$20	No	0%	Lower cost brand-name drugs
• Third Tier	$35	No	0%	Higher cost brand-name drugs
Mail Order (up to 90 day supply)				
• First Tier	$18	No	0%	Typically generic drugs
• Second Tier	$33	No	0%	Lower cost brand-name drugs
• Third Tier	$63	No	0%	Higher cost brand-name drugs
Dental Services – The Basic Plan includes most services except prosthetic, complex restorative and orthodontic. Covered expenses are not subject to a deductible and limited to a $1200 calendar year maximum				
• Diagnostic/Preventative Services	$0	No	0%	
• Primary Services	$0	No	20%	
Optional Benefits – These benefits can be purchased by the Employer at an additional cost to supplement the Basic Plan.				
Expanded Dental/Vision				
Expanded Dental – these benefits are available in addition to the basic dental services				
• Prosthetic and Complex Restorative	$0	No	50%	
• Orthodontic	$0	No	50%	Lifetime maximum $1200
Vision – benefits are limited to once every 24 months				
• Eye Exam	$30	No	0%	
• Frames	$75 benefit maximum			
• Lenses				
o Single Vision	$50 benefit maximum			
o Bifocal	$75 benefit maximum			
o Trifocal	$100 benefit maximum			
o Contacts	$100 in lieu of eyeglass lenses			

Value Alliance - No Out of Network Benefits other than Emergency

Plan Year Deductible $300 per Covered Person Not to Exceed $900 per Family
Plan Year Out-of-Pocket Limits $2500 per Covered Person Not to Exceed $7500 per Family

	Co-Payment	**Deductible Applies?**	**Coinsurance**	**Comments:**
Accidental Dental Injuries	$20 PCP/$35 Specialist if in office	Yes, if IP/OP treatment	20% if IP/OP treatment	
Ambulance Travel	$0	Yes	20%	
Diagnostic test and x-rays				
• Inpatient	$0	Yes	20%	
• Outpatient	$0	Yes	20%	
• Office	$0	Yes	20%	
Doctor's Visits				
Inpatient				
• Primary Care Physician (PCP)	$0	Yes	20%	
• Specialist	$0	Yes	20%	
Outpatient /Office				
• Primary Care Physician (PCP)	$20	No	0%	
• Specialist	$35	No	0%	
Home Health Care	$0	Yes	20%	90-visit CY Limit
Hospice Care Services	$20 PCP/$35 Specialist	No	0%	
Hospital Services				
• Inpatient Facility	$0	Yes	20%	
• Outpatient Facility, including ER visits	$0	Yes	20%	
Mental Health or Substance Abuse Treatment				
Inpatient Treatment				
• Facility	$0	Yes	20%	
• Professional Provider Services	$0	Yes	20%	
Partial Day Program	$0	Yes	20%	
Outpatient Treatment				
• Facility Services	$0	Yes	20%	
• Specialist	$35	No	0%	
Employee Assistance Program	$0	No	0%	Four visits per incident
Nursing Services – Private Duty	$0	Yes	20%	
Skilled Nursing Facility				
• Facility	$0	Yes	20%	100 day per stay limit
• Professional Provider Services	$0	Yes	20%	
Surgery				
Inpatient				
• PCP/Specialist	$0	Yes	20%	
• Assistant Surgeon/ Anesthesiologist	$0	Yes	20%	
Outpatient, incl. Oral Surgery				
• PCP	$20	Yes	20%	
• Specialist incl. Anesthesiologist	$30	Yes	20%	
Routine Wellness/Preventative care (All Ages)				

Annual check-up				
• PCP	$20	No	0%	
• Specialist	$35	No	0%	
Immunizations	$0	Yes	20%	
Lab and x-ray services	$0	Yes	20%	
Preventative Care				
Annual gynecological exam				
• PCP	$20	No	0%	
• Specialist	$35	No	0%	
Annual Pap test	$0	Yes	20%	
Annual mammography screening, beginning at age 35	$0	Yes	20%	
Annual Prostate exam (digital rectal exam), beginning at age 40				
• PCP	$20	No	0%	
• Specialist	$35	No	0%	
Annual Prostate specific antigen test, beginning at age 40	$0	Yes	20%	
Colorectal cancer screening	$0	Yes	20%	
Prescription Drugs				
Retail pharmacy (per 34 day supply)				
• First Tier	$15	No	0%	Generally generic drugs
• Second Tier	$20	No	0%	Lower cost brand-name drugs
• Third Tier	$35	No	0%	Higher cost brand-name drugs
Mail Order (up to 90 day supply)				
• First Tier	$18	No	0%	Generally generic drugs
• Second Tier	$33	No	0%	Lower cost brand-name and some generic drugs
• Third Tier	$63	No	0%	Higher cost brand-name drugs
Dental Services –Covered expenses are not subject to a deductible and limited to a $1200 calendar year maximum				
• Diagnostic/Preventative Services	$0	No	0%	
• Primary Services	$0	No	20%	
• Prosthetic and Complex Restorative	$0	No	50%	
• Orthodontic	$0	No	50%	Lifetime maximum $1200

SCHEDULE OF BENEFITS *Attachment 1 C*

	Individual	Family
Calendar Year Deductible:	$	$
Annual Out-of-Pocket Limits	$	$
Lifetime Maximum	$	

Basic Benefits	**Co-Payment**	**Deductible Applies?**	**In-network Coinsurance**	**Comments:**
Accidental Dental Injuries				
Ambulance Travel				
Diagnostic Test and X-rays				
• Inpatient				
• Outpatient, including Office				
Doctor's Visits				
Inpatient				
• Primary Care Physician (PCP)				
• Specialist				
Outpatient /Office				
• Primary Care Physician (PCP)				
• Specialist				
Home Health Care				
Hospice Care Services				
Hospital Services				
• Inpatient Facility				
• Outpatient Facility, including ER visits				
Mental Health or Substance Abuse Treatment				
Inpatient Treatment				
• Facility				
• Professional Provider Services				
Partial Day Program				
Outpatient Treatment				
• Facility Services				
• Specialist				
Employee Assistance Program				
Medical Equipment, Appliances and Supplies				
Nursing Services – Private Duty				
Oral Surgery				
Skilled Nursing Facility				
• Facility				
• Professional Provider Services				
Surgery				
Inpatient				
• PCP/Specialist				
• Assistant Surgeon				
• Anesthesiologist				
Outpatient				
• PCP				
• Specialist				
• Anesthesiologist				
Wellness Services				
Well child through age 6				
• PCP				
• Specialist				
Screening Tests				
Routine Wellness/Preventative care (Age 7 and older)				

Annual check-up				
• PCP				
• Specialist				
Immunizations				
Lab and x-ray services				
Preventative Care				
Annual gynecological exam				
• PCP				
• Specialist				
Annual Pap test				
Annual mammography screening, beginning at age 35				
Annual Prostate exam (digital rectal exam), beginning at age 40				
• PCP				
• Specialist				
Annual Prostate specific antigen test, beginning at age 40				
Colorectal cancer screening				
Prescription Drugs				
Retail pharmacy (per 34 day supply)				
• First Tier				
• Second Tier				
• Third Tier				
Mail Order (up to 90 day supply)				
• First Tier				
• Second Tier				
• Third Tier				
Dental Services				
• Diagnostic/Preventative Services				
• Primary Services				
• Prosthetic and Complex Restorative				
• Orthodontic				
Out-of Network Benefits				
Vision and Hearing				
Vision Benefit				
• Eye Exam				
• Frames				
• Lenses				
o Single Vision				
o Bifocal				
o Trifocal				
o Contacts				
Hearing Benefit				
• Exam				
Hearing Aid(s) & related services				
Other Benefits:				

COMMONWEALTH OF VIRGINIA

EMPLOYEE HEALTH BENEFITS PROGRAM PROCUREMENT

Statewide Self-Funded Mental Illness Substance Abuse (MISA) Questionnaire

Completion of this schedule's enclosed questionnaire and exhibits in the formats provided will constitute the Technical and Cost Management Capabilities portion of the offeror's Proposal. Completion of the appropriate RFP Attachment 2, Schedules 2-1 through 2-8 is also required for a complete proposal. The contents of the MISA Questionnaire are:

Contents	
Questionnaire	A questionnaire that allows each offeror to describe its technical capabilities in general terms (e.g., organization, history, financial stability, etc.) as well as specific areas that will form the evaluation framework for the offeror's proposal (e.g., Network Service and Quality). Sections I through V of the questionnaire constitute the forms and information required for the Technical and Cost Management evaluation. Please complete them in full. The questionnaire will direct the offeror to supporting exhibits that are to be completed in full, in the format provided. The primary exhibit contents are described below. **PLEASE NOTE:** All exhibits should be placed on the page immediately following the applicable question**, NOT** in a separate binder or section. The few exceptions (i.e., Geo-Access Report) will be clearly noted in the applicable question set.
MISA Capabilities -- Exhibits	
Exhibit 1	*Organization Chart*
Exhibit 2	*Member Access-MISA and EAP* (Question III. 3)
Exhibit 3	*Patient Satisfaction Standards* providing historical results of patient satisfaction surveys (Questions MISA III.8; EAP III. 11)
Exhibit 4	*Standard Reports* (follow instructions provided in Question IV. 3)
Cost Forms	MISA/EAP applicable schedules provided in RFP Attachment 2 submitted in accordance with instructions in RFP Section.6.0, *Form of Response*.

EMPLOYEE HEALTH BENEFITS PROGRAM PROCUREMENT

Mental Illness Substance Abuse (MISA) Questionnaire

Completion of this questionnaire and its referenced supporting exhibits will constitute each offeror's Technical and Cost Management Capabilities description for the following plan described in this RFP:

STATEWIDE SELF-FUNDED MISA AND EAP PLANS
State Employee Plan and TLC

1. This plan will be packaged with the self-funded statewide Medical/Surgical plan being procured under RFP-OHB03-2 (i.e., the same, single MISA Plan will be packaged with the self-funded PPO. Also, it will be packaged with any less-than-statewide, self-funded plan procured under OHB03-2.). Please note, there are two benefit programs being procured, the state employee program and The Local Choice (TLC) program for local government and schools.

2. Regarding the EAP services, the Department is considering the option of offering one EAP to all state employees and not just those eligible for and enrolled in a health plan, as is currently the policy. This proposal option impacts the state employee program only. The TLC program will have the same MISA and EAP vendor covering the same population.

3. Therefore, vendors may propose on the following bases:

   a. For TLC: MISA and EAP must be proposed by each offeror.

   b. For the state employee program: an offeror may propose MISA only, EAP only, or both. If EAP is proposed, two options must be presented:

      (1) One covering only those participating in the state employee plans

      (2) One covering all 150,000 state employees, including those not currently in the health plans

4. A self-funded ASO arrangement is contemplated. The cost forms in Attachment 2 and applicable questions in this document will permit you to make a proposal on this basis. The Department may consider a risk-sharing arrangement, and a question on this topic is included in this Questionnaire.

Please provide a direct response to all of the questions below and follow directions for submission of supporting exhibits. Utilizing the MS Word file you have been provided, restate the question, then supply your response. Exhibits should be provided, in order, following your questionnaire responses. RFP Attachment 2 Schedules referenced herein should be submitted as directed in the RFP Form of Response (Section 6.0) and Attachment 2 instructions. If a given response is lengthy or redundant to more than one question, provide a brief cross-reference to an attachment (or the similar response to another question). Your responses should be contained in a loose-leaf notebook and ***not be bound***.

Data, especially audited data, are preferred to simple assertions. Systems and other well organized, clear charts or exhibits may serve in lieu of a narrative.

General

1. a. The RFP describes task and benefit specifications (Section 2.0); Standards of Performance (Section 3.0); and Reporting Requirements (Section 4.0). Under the appropriate evaluation section below, you will be requested to affirm that you will fully comply and meet these specifications as stated. Be advised that failure to identify any deviation in response to the appropriate question constitutes a representation on the offeror's part that the specifications will be met precisely as written. ***Your response must also contain any demurrals and the reasons thereof. The absence of demurrals shall constitute a representation that the offeror will provide services and reports exactly as requested by the Department. The absence of clearly stated demurrals in Tab 1 of your proposal, in the form described in Section 6.0 of the RFP, constitutes a representation that the offeror is capable of providing the services and reports exactly as requested as of the day the proposal is submitted.*** In the space below, please acknowledge that you understand and have complied with this requirement.

   b. Appendices to this RFP and the CD disk available to prospective offerors contain key claims and enrollment data. The Attachment 2 Schedules contain instructions and require the use of certain data and assumptions when completing your offeror's exhibits. If you have any demurrals, as defined above, and/or ***not used*** the data and/or assumptions, say such here and affirm that you clearly noted the exception in your response to the specific question.

2. Certain of the questions below may cause offerors to provide different answers for the State plan versus The Local Choice plan options. Where this is the case, please clearly distinguish the differences and impact on the respective plans. As your written response to this question, please state below that you understand and have complied with this requirement.

3. Please certify below that you have an active business plan in place to enable your organization to comply in a timely manner with HIPAA's administrative simplification standards relating to electronic data interchange (EDI); that you have the necessary systems capacity to fully implement the EDI standards; and that it is in full compliance with the EDI standards.

4. Please certify below that you are able to comply with HIPAA's regulations protecting the privacy of individually identifiable health information, and that you will fully comply with HIPAA's information privacy requirements.

5. You will be expected to sign a Business Associate Agreement with the Commonwealth. Please state your agreement to do so here.

6. What safeguards do you provide to protect patient privacy?

7. Note that the questionnaire sections are divided into MISA and EAP sub-sections. For those proposing both benefit plans, please respond to both sections, even if answers are identical for both. Please be careful, however, to distinguish between both programs and do not provide a single global response to both questions if different systems, providers, administrative units, management/supervisory staff; networks; subcontractors; etc will be used to administer the MISA versus EAP components.

I. A. Organization and Financial Stability - MISA (10 points)

This section asks offerors to provide a brief background of your organization.

1. Identify the type of MISA network you propose (e.g., Network Only, Point of Service, etc.). If any network component is rented, leased, or managed by an affiliate party or sub-contractor, identify such here and provide the information below for all parties. If multiple parties in multiple sites will be involved in administration of this contract, please provide a chart identifying all parties and/or locations.

2. Briefly describe your organization's history and parent organizational ties, if applicable.

3. Provide the number of customers and members (or employees -- specify) covered in the State of Virginia as of January 1, 2003, under your managed mental health care products.

Plan Type	# Group Plan Customers	# Members	# Employees
MISA			

4. Submit evidence of appropriate liability insurance protection.

5. As directed in Section 6.0 of the RFP, please submit, under Tab **5** of your proposal, a copy of your most recent audited financial statements (balance sheet, income statement and flow of funds).

6. Please indicate any recent or anticipated changes in the offeror's corporate structure, such as mergers, acquisition, new venture capital, stock issue, etc.

7. Please include three current client references for whom you provide similar MISA services to those requested in this RFP, preferably public entities, preferably plans with 25,000 or more employees.

REFERENCE #1	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

REFERENCE #2	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

REFERENCE #3	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

8. Please provide references for two former clients for whom you previously provided similar MISA services (should not include lost contracts due to mergers or other neutral causes).

REFERENCE #1	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

REFERENCE #2	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

9. Please provide information as to length of time your firm or organization has been operational in providing managed MISA services in the Commonwealth of Virginia.

II. A. Qualifications of Staff – MISA - (10 points)

This section asks offerors to identify the staff personnel and qualifications for the personnel who will be assigned to this account.

1. Identify the accountable senior person who will be responsible for managing the relationship with the Contractor, including these negotiations.

Senior Account Manager *(individual responsible for managing the relationship)*	
Title	
Office Location	
Contact E-mail Address	
Contact Phone Number	
Years of Experience	
Years of Service with current Co.	
# Accounts Currently Servicing	

2. Complete Exhibit 1, an organizational chart that will identify key management personnel (i.e., those who will directly support this contract), including the following information:

   - their dedicated time allocation to this contract,
   - the office locations responsible for managing the various duties associated with fulfilling all of the provisions of this contract, and
   - the number of years of experience in handling contracts similar in scope to the Commonwealth's.

EXHIBIT 1

EMPLOYEE HEALTH BENEFITS PROGRAM PROCUREMENT

MISA Organization Chart

Provide an organizational chart, including title and office location, that:

1. Identifies key personnel, for example, those managers who will directly support this contract, and whose performance appraisal is impacted by their performance on this contract. Do not include first-line supervisor personnel at this point. Be sure to include, at least, the below functions. Also, please indicate the expected percentage of time that each manager will devote to this contract.

    a. Senior Corporate Officer with ultimate decision-making authority for this contract

    b. Account Manager

    c. Network Building/Provider Relations Manager(s)

    d. Administration Managers (Claims, Billing, etc.)

    e. Customer Service Manager

    f. Medical Director

    g. Utilization Review Director

    h. Senior Underwriter

2. If in the foreseeable future there is a reasonable chance that any of these individuals will be reassigned, retire, or otherwise be unavailable to fulfill the duties described herein, please identify the replacement(s). Also, provide all of the requested information about any such individual.

3. Provide, as an attachment to your chart, resumes for these individuals. Resumes should clearly identify the number of years performing directly related activities and reference current, similarly situated customers.

3. **Case Managers**

   a. How many full-time equivalent (FTEs) case managers will be assigned to the Commonwealth's contract?

   b. Will these case managers be dedicated solely to the Commonwealth's contract?

   c. What is your standard for assigning full-time case managers to the Commonwealth of Virginia's account (i.e., one full-time case manager per 17,000 covered members)?

   d. What are the qualifications (e.g., educational degrees, years of experience, clients served) of the case managers to be assigned to the contract?

   e. Do you anticipate hiring additional case managers to administer the contract? If so, how many?

   f. What type of formal training is done for your case managers?

4. **Physicians & Doctor Level Professionals**

   a. Please indicate the number of FTEs and qualifications of physicians and doctor-level professional staff employed by your company who are available ***on-site*** to provide clinical supervision, collaboration and/or intervention in difficult cases.

   b. Identify the number of years of clinical experience and experience with a managed care organization for each.

   c. How many physicians and doctor-level professionals employed by your company and ***located on-site*** will be dedicated to the Commonwealth's contract?

   d. What is your standard for assigning FTE physicians and doctor-level professional staff employed on-site dedicated to the Commonwealth's contract?

5. **Counselors/Coordinators**

   a. How many FTE intake counselors/coordinators does your company currently employ?

   b. Identify the number of years of customer service experience for each.

   c. How many would be assigned to the Commonwealth's contract?

   d. What is your standard for assigning FTE intake counselors/coordinators to the Commonwealth's account (i.e., one FTE intake counselor/coordinator per 40,000 covered members)?

   e. Do you anticipate hiring any additional intake counselors/coordinators should you be awarded the Commonwealth contract? If so, how many?

   f. What type of formal training is done for your intake counselors/coordinators?

6. **24-hour Line (800#)**

   a. Describe the minimum qualifications of staff who answer calls on your 24-hour line.

   b. Indicate the average experience of staff answering calls during business hours and after hours.

   c. Indicate the minimum level of staffing (full time employees per 1,000 covered lives) for your 24 hour line.

   d. What percentage are administrative staff and what percentage are clinical staff?

   e. Where are staff members answering the 800 line physically located?

III. A. Network Service and Quality – MISA - (20 points)

This section asks offerors to describe their network capabilities in terms of access to participating providers for the Commonwealth's employees. This section also asks offerors to describe their capabilities in terms of quality assurance, improvement and planning.

1. Please indicate your NCQA accreditation status.

2. Under the network you are proposing, are you willing to assume ***ownership*** (i.e., responsibility for recruiting providers, exercising quality control, managing service and claim adjudicators, and defending actions by allegedly wronged parties)? If not unconditional, describe your conditions for ***ownership*** in detail. (Note: The Commonwealth's intent is ***not*** to own the network.)

3. Define the scope and availability of your MISA network providers by completing a geo-access report with the below access standards. Include the summary pages for assessment and other clinicians (psychiatrists, psychologists, LCSWs, MSWs) and hospitals following this question, include the entire report as an attachment (please note the location here), and you must provide an electronic file containing the match results. Preferred formats for the electronic file are ASCII (include the file format), Access or Excel.

Type of Provider	Percent of Employees	Distance
One acute care hospital	90% of employees	60 miles
Two clinicians	90% of employees	30 miles

4. Provide, as a supplemental attachment, your most recent, comprehensive provider directory for the network being offered. Directories should clearly indicate the general areas of the State covered by the directory. Also include provider directories for the areas of Tennessee, Maryland, DC, North Carolina, and West Virginia, where members reside out-of-state. Please differentiate between MISA and EAP network providers, where applicable. Reference the location of the directories in your proposal here.

5. Regarding network building and management:

   a. Briefly describe, in management summary fashion, the critical activities, steps and concepts you use in building and maintaining the clinician component of your proposed network. The steps described should include, but are not confined, to:

      (1) The criteria used for selection of clinicians in terms of geographic access and additional patient load accepted.
      (2) Recruiting procedures.
      (3) Credentialling; other qualifications assurance steps.
      (4) Continual monitoring of referral patterns and utilization of services.

Complete the tables below regarding credentialing/monitoring activities:

CREDENTIALING PROCESS	YES/NO
Your organization verifies at least the following information from primary sources:	
- current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the state	
- clinical privileges in good standing at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable	
- Graduation from an accredited professional school	
- Board certification if the practitioner states that he/she is board-certified on the application	
- Work history for the past five years	
- Current, adequate malpractice insurance according to your organization's policy	
- History of professional liability claims which resulted in settlements or judgements paid by or on behalf of the practitioner	
Indicate whether each applicant completes a credentialing application that includes a statement by the applicant regarding:	
- lack of present illegal drug use	
- history of loss of license and/or felony convictions	
- history of loss or limitation of privileges or disciplinary activity	
- applicant attests to the correctness and completeness of application	
Prior to making credentialing decision, your organization receives information appropriate to the practitioner's discipline, including:	
- information from the State Board of Licensure or Certification and/or the National Practitioner Data Bank	
- Information about sanctions or limitations on licensure from the appropriate state agency of the Federation of State Medical Boards	
- Review of previous sanction activity by regional Medicare and Medicaid offices	
Licensed behavioral healthcare professional staff from your organization conducts visits to the offices of all potential behavioral healthcare practitioners prior to their acceptance for network inclusion	

b. Does your firm recredential its practitioners at least every two years? If not, please indicate the frequency for recredentialling.

c. In your recerdentialing process, please indicate whether or not the items listed below are completed/reviewed in the process.

RECREDENTIALING PROCESS	YES/NO
Your organization verifies at least the following information from primary souces:	
- current valid state license to practice	
- status of clinical privileges at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable	
- Graduation from an accredited professional school	
- Board certification (only if the practitioner was due to be recertified)	
- Current, adequate malpractice insurance according to your organization's	

RECREDENTIALING PROCESS	YES/NO
policy	
- History of professional liability claims which resulted in settlements or judgements paid by or on behalf of the practitioner	
Indicate whether your organization incorporates data from the following sources in its recredentialing/decision making process	
- member complaints	
- clinical record reviews	
- member satisfaction	
- on-site visits conducted by qualified behavioral health professionals from your organization	
Your organization confirms that the practitioner is in good standing with the state and federal regulatory bodies	

d. As above, briefly describe the critical activities, steps and concepts you use for building and maintaining the hospital component of your proposed network.

e. For what period of time are your provider contracts generally negotiated? What type of roll-out agreement is included in your provider contract to assure the Commonwealth that providers will continue to treat the Commonwealth's employees until the end of the plan year (June 30 or September 30 for TLC)?

f. What commitment are you willing to make to assure the Commonwealth that a sufficient number of providers will be available to meet the needs of all Commonwealth employees?

5. Please summarize the major elements of your formal quality assurance program. Describe the activities used to assure the minimal standards are met for day-to-day performance.

6. Describe the technical instruments used to measure and continuously monitor information about processes and procedures.

7. Identify the main quality management initiatives planned for 2004 and 2005.

8. Describe your patient satisfaction surveying/assessment methodology. Provide, as Exhibit 3 following this question, the most recent two years' ***patient satisfaction*** results for the network you are offering. Affirm below that you will comply with paragraph.4.1.6. of this RFP, and conduct annual surveys of Commonwealth of Virginia patient satisfaction.

9. Briefly describe your telephonic automated call distribution (ACD) system capabilities currently available.

10. a. Affirm that you will have a fully trained, dedicated member service function devoted to administration of the Commonwealth's plan. Where will the member service unit reside? What real-time data will be available to the representatives?

b. Attach a list of individuals (i.e., line supervisors and staff) who would be assigned to this member service unit, noting their years of direct experience in member service to large (1,000+ employees) employer plans.

11. Identify any member service factors not provided in the response to the above questions that you believe make you uniquely qualified to administer the Commonwealth's MISA plan.

12. Provide, under Tab 3, a sample of the employee communication materials that all members are to receive that are intended to meet the requirements of paragraph 6.3 of this RFP.

IV. A. Administrative Capability – MISA - (20 points)

This section asks offerors to describe their customer service standards, results and management process, as well as their administrative/systems capabilities and to affirm standards of performance identified in RFP Section 3.0.

1. Describe your current automated information management system. How long has your current system been fully operational? If more than one system is involved, or the system is split, please provide a chart listing all systems and clearly describe the nature and timing of interfaces.

2. a. Is there an on-line system for logging receipt of treatment plans and matching to authorization periods?

   b. Are treatment plan authorizations generated on-line?

   c. Can authorizations for a specified time period be amended or revised on-line?

   d. Describe other functions your automated information system performs.

   e. Please describe how you will integrate EAP services with managed MISA providers if the Commonwealth were to not utilize your EAP services. What are your interface requirements?

3. Affirm below that you can meet all of the ***standards of performance*** detailed in RFP Section 3.0, and provide reports verifying results.

   a. Affirm that you will comply with Schedule of Liquidated Damages described in RFP paragraphs 3.6. and 3.7.

   b. Include below, as Exhibit 4, a complete list of standard reports you can provide to the Commonwealth to demonstrate you are meeting the Standards in the areas noted in question IV.3. above. Provide samples as a supplementary attachment (and note location in your proposal here).

4. Affirm that you can meet all of the administrative tasks, specifications and reporting requirements identified in RFP Sections 2.0 and 4.0 and the *Special Terms and Conditions* in Section 8.0. Identify if your firm plans on being able to produce an annual MISA HEDIS (or similar) report for the Commonwealth of Virginia.

5. *Form of Response*, paragraph 6.2., requires submission of benefit descriptions being proposed. Submit, under Tab 2, and affirm that you have complied with paragraph 6.2 here. ***Be sure*** that clear, distinctive descriptions are provided for both statewide plan benefits and the Local Choice (TLC) options.

6. Provide a brief summary below, and complete descriptions as supplemental attachments, of the following administrative processes and systems (note location of the attachments in your proposal here). Carefully annotate which processes are automated and which are manual and where the systems/people interfaces occur. If more than one system is involved, or the system is split, please provide: a chart listing all systems and interfaces; location of the systems; and a clear description of the nature and timing of interfaces:

a. ***Member Services***: Describe your processes and controls in providing member services (by phone, letter, in person and/or on-line). Include the functions of: (1) inquiries on benefit and provider information; and (2) handling complaints on providers, administrative/service issues, and/or claim appeals.

b. ***Claim Processing Services***: Describe the claim processing system, including referral, clinical and network pricing interfaces, for in-network and out-of-network claims:

(1) Describe how records are maintained, backed up, stored, and retrieved. (Include any provisions for recovery from disaster)

(2) Explain how records are secured and how confidentiality of information is protected

(3). The security of the system, including safeguards against employee embezzlement and theft are very important

(4). Supply a sample EOB with EOB messages.

(5) Include a detailed description of the edits used to ensure the integrity of the data and to guard against duplicate payments

(6) Describe coordination of benefits (COB) procedures

c. ***Membership Accounting Services***: Describe the billing processes for the State plan, and the Local Choice, and COBRA requirements described in RFP Section 8.0 (see Appendices 8 and 9). Be sure to clearly state the services (e.g., number of bills) that are included in your cost proposal versus those at an additional charge. Any additional charges identified must be completely cross-referenced to your response to the cost attachments (i.e., if you describe an optional service or incremental cost to service transactions above a certain amount at $X fee, that service and fee must be included in your cost attachment under an optional label). Timing and reconciliation are critical. Describe the proposed process in detail, including the correction/reconciliation step.

d. ***Systems Development***: Provide the implementation date of the most recent substantive changes to your administration systems. If a future change is contemplated between this date and July 1, 2004, please provide a brief description of the changes and implementation dates.

7. Affirm here that you will meet the claim tape mandatory requirement described in paragraph 2.7.

V. A. Benefit Cost Management, and Administrative Cost - MISA (35 points)

This section asks offerors to describe their capabilities in terms of controlling MISA utilization through case management and requests cost information.

1. Any systems and interfaces involved with the functions addressed in this section that were NOT described and diagramed in your response to Section IV of this questionnaire must be described below (in the form required in Section IV).

2. Describe in detail the information required for processing a provider treatment plan.

3. Describe in detail the process for approving treatment plans.

4. What is your standard turn-around time for approving or dis-approving a provider treatment plan?

5. How do your actual results compare to your standard turn-around time over the past 12 months?

6. Describe in detail your pre-admission and continued hospital stay certification process for inpatient care, including the nature and timing of the contact with the provider(s) and the patient.

7. How are the specifications of approved treatment formally communicated to the provider, the treatment facility and to the patient?

8. How do the certification and notification processes differ between in-network, out-of-network and out-of-area providers? Provide examples.

9. During what hours of the day are pre-admission and continued hospital stay certification services provided?

10. How is an emergency inpatient admission defined and how is it certified (during regular hours and during weekends or after hours)? Please include any differences between certifying an admission to in-network and out-of-network facilities.

11. Please briefly describe the criteria used to guide case manager decisions regarding approval of acute inpatient hospital admissions, emergency inpatient, intensive outpatient, partial day inpatient, individual/group outpatient treatment for adults, adolescents and children. Provide specific Diagnostic and Statistical Manual (DSM) diagnostic categories that would be excluded from any particular level of care. Do the criteria vary geographically? If so, how?

12. a. What are the standard number of inpatient days and number of outpatient treatment sessions that are approved for a patient's initial treatment in the following conditions?

Condition	Standard # Inpatient Days	Standard # Outpatient Treatment Sessions
Drug/Alcohol		
Mental Health		

b. How frequently is the approved care (inpatient and outpatient) reviewed?

c. For outpatient care, is the review of the clinical assessment always, sometimes or never done by the same person?

d. Describe the procedures for how an initial request for hospitalization is denied, a request for additional hospitalization is denied, and a request for additional outpatient visits is denied.

10. Describe what follow-up action is taken by your company when patients drop out of treatment against medical advice.

11. Explain your standard procedures for coordinating utilization review with the Commonwealth's EAP and Medical-Surgical plans, including a description of the responsibilities and authority of those plans and your organization.

12. Please describe in detail the after-care monitoring services you provide, including the frequency to follow up, the criteria for determining when to contact the patient or family directly (rather than contacting the after-care provider for information), criteria for intervention, amount of contact with the client's EAP, etc.

13. Describe the criteria used to determine if the intensive treatments are successful, and the criteria used to assess a patient's progress or outcome.

14. Provide the approval and non-approval treatment rates for inpatient and outpatient for calendar year 2002.

15. Submit your cost proposal in accordance with the instructions contained in RFP Section 6.0 and Attachment 2.

16. The specifications provide for a self-funded arrangement for MISA benefits. Would you be willing to enter into a risk sharing agreement?

17. As stated in the RFP, the state plan benefits changed July 1, 2003. Please affirm here that your cost proposal recognizes these changes and that your claims projections in Schedule2-1 reflect your best estimate of the appropriate benefit adjustment factors.

I.B. Organization and Financial Stability – EAP - (10 points)

This section asks offerors to provide a brief background of your organization.

1. Identify the type of EAP network you propose. If any network component is rented, leased, or managed by an affiliate party or sub-contractor, identify such here and provide the information below for all parties. If multiple parties in multiple sites will be involved in administration of this contract, please provide a chart identifying all parties and/or locations.

2. Describe in detail how your EAP program works, assuming the current four-visit model. Point out any distinguishing characteristics of your EAP program.

3. Briefly describe your organization's history and parent organizational ties, if applicable.

4. Provide the number of customers and members (or employees – specify) covered in the Commonwealth of Virginia as of January 1, 2003, under your EAP products.

Plan Type	# Group Plan Customers	# Members	# Employees
EAP			

5. Submit evidence of appropriate liability insurance protection.

6. As directed in Section 6.0 of the RFP, please submit, under Tab **5** of your proposal, a copy of your most recent audited financial statements (balance sheet, income statement and flow of funds).

7. Please indicate any recent or anticipated changes in the offeror's corporate structure, such as mergers, acquisition, new venture capital, stock issue, etc.

8. Please include three current client references for whom you provide similar EAP services to those requested in this RFP, preferably public entities, preferably plans with 25,000 or more employees.

REFERENCE #1	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

REFERENCE #2	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	

Services Provided by Your Organization	

REFERENCE #3	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

9. Please provide references for two former clients for whom you previously provided similar EAP services (should not include lost contracts due to mergers or other neutral causes).

REFERENCE #1	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

REFERENCE #2	
Name	
Street Address	
City, State, Zip	
Phone Number	
Number of Employees Covered	
Services Provided by Your Organization	

10. Please provide information as to length of time your firm or organization has been operational in providing managed EAP services in the Commonwealth of Virginia.

II. B. Qualifications of Staff – EAP - (10 points)

This section asks offerors to identify the staff personnel and qualifications for the personnel who will be assigned to this account. Provide responses for both EAP scenarios (health plan participants only and all 150,000 state employees.)

1. Identify the accountable senior person who will be responsible for managing the relationship with the Contractor, including these negotiations.

Senior Account Manager *(individual responsible for managing the relationship)*	
Title	
Office Location	
Contact E-mail Address	
Contact Phone Number	
Years of Experience	
Years of Service with current Co.	
# Accounts Currently Servicing	

2. Complete Exhibit 1, an organizational chart that will identify key management personnel (i.e., those who will directly support this contract), including the following information:

   - their dedicated time allocation to this contract,
   - the office locations responsible for managing the various duties associated with fulfilling all of the provisions of this contract, and
   - the number of years of experience in handling contracts similar in scope to the Commonwealth's.

EXHIBIT 1

EMPLOYEE HEALTH BENEFITS PROGRAM PROCUREMENT

EAP Organization Chart

Provide an organizational chart, including title and office location, that:

1. Identifies key personnel, for example, those managers who will directly support this contract, and whose performance appraisal is impacted by their performance on this contract. Do not include first-line supervisor personnel at this point. Be sure to include, at least, the below functions. Also, please indicate the expected percentage of time that each manager will devote to this contract.

    a. Senior Corporate Officer with ultimate decision-making authority for this contract

    b. Account Manager

    c. Network Building/Provider Relations Manager(s)

    d. Administration Managers (Claims, Billing, etc.)

    e. Customer Service Manager

    f. Medical Director

    g. Utilization Review Director

    h. Senior Underwriter

4. If in the foreseeable future there is a reasonable chance that any of these individuals will be reassigned, retire, or otherwise be unavailable to fulfill the duties described herein, please identify the replacement(s). Also, provide all of the requested information about any such individual.

5. Provide, as an attachment to your chart, resumes for these individuals. Resumes should clearly identify the number of years performing directly related activities and reference current, similarly situated customers.

3. **Case Managers**

   a. How many full-time equivalent (FTEs) case managers will be assigned to the Commonwealth's contract?

   b. Will these case managers be dedicated solely to the Commonwealth's contract?

   c. What is your standard for assigning full-time case managers to the Commonwealth of Virginia's account (i.e., one full-time case manager per 17,000 covered members)?

   d. What are the qualifications (e.g., educational degrees, years of experience, clients served) of the case managers to be assigned to the contract?

   e. Do you anticipate hiring additional case managers to administer the contract? If so, how many?

   f. What type of formal training is done for your case managers?

4. **Physicians & Doctor Level Professionals**

   a. Please indicate the number of FTEs and qualifications of physicians and doctor-level professional staff employed by your company who are available ***on-site*** to provide clinical supervision, collaboration and/or intervention in difficult cases.

   b. Identify the number of years of clinical experience and experience with a managed care organization for each.

   c. How many physicians and doctor-level professionals employed by your company and ***located on-site*** will be dedicated to the Commonwealth's contract?

   d. What is your standard for assigning FTE physicians and doctor-level professional staff employed on-site dedicated to the Commonwealth's contract?

5. **Counselors/Coordinators**

   a. How many FTE intake counselors/coordinators does your company currently employ?

   b. Identify the number of years of customer service experience for each.

   c. How many would be assigned to the Commonwealth's contract?

   d. What is your standard for assigning FTE intake counselors/coordinators to the Commonwealth's account (i.e., one FTE intake counselor/coordinator per 40,000 covered members)?

   e. Do you anticipate hiring any additional intake counselors/coordinators should you be awarded the Commonwealth contract? If so, how many?

   f. What type of formal training is done for your intake counselors/coordinators?

6. **24-hour Line (800#)**

   a. Describe the minimum qualifications of staff who answer calls on your 24-hour line.

   b. Indicate the average experience of staff answering calls during business hours and after hours.

   c. Indicate the minimum level of staffing (full time employees per 1,000 covered lives) for your 24 hour line.

   d. What percentage are administrative staff and what percentage are clinical staff?

   e. Where are staff members answering the 800 line physically located?

III. B. Network Service and Quality – EAP - (20 points)

This section asks offerors to describe their network capabilities in terms of access to participating providers for the Commonwealth's employees. This section also asks offerors to describe their capabilities in terms of quality assurance, improvement and planning.

1. Please indicate your NCQA accreditation status.

2. Under the network you are proposing, are you willing to assume ***ownership*** (i.e., responsibility for recruiting providers, exercising quality control, managing service and claim adjudicators, and defending actions by allegedly wronged parties)? If not unconditional, describe your conditions for ***ownership*** in detail. (Note: The Commonwealth's intent is ***not*** to own the network.)

3. Define the scope and availability of your EAP network providers by completing a geo-access report with the below access standards. Include the summary pages following this question, include the entire report as an attachment (please note the location here), and you must provide an electronic file containing the match results. Preferred formats for the electronic file are ASCII (include the file format), Access or Excel.

PRACTICE SPECIALTY	# PROVIDERS	MILES
Certified Employee Assistance Professionals	2	15
Certified Addiction Counselors	2	15

4. Provide, as a supplemental attachment, your most recent, complete provider directory for the network being offered. Directories should clearly indicate the general areas of the State covered by the directory. Also include provider directories for the areas of Tennessee, Maryland, DC, North Carolina, and West Virginia, where members reside out-of-state. Please differentiate between MISA and EAP network providers, where applicable. Reference the location of the directories in your proposal here.

5. Regarding network building and management:

   a. Briefly describe, in management summary fashion, the critical activities, steps and concepts you use in building and maintaining the clinician component of your proposed network. The steps described should include, but are not confined, to:

      (1) The criteria used for selection of clinicians in terms of geographic access and additional patient load accepted.
      (2) Recruiting procedures.
      (3) Credentialling; other qualifications assurance steps.
      (4) Continual monitoring of referral patterns and utilization of services.

Complete the tables below regarding credentialling/monitoring activities:

CREDENTIALING PROCESS	YES/NO
Your organization verifies at least the following information from primary sources:	
- current valid license to practice as an independent behavioral healthcare practitioner at the highest level certified or approved by the state	
- clinical privileges in good standing at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable	
- Graduation from an accredited professional school	
- Board certification if the practitioner states that he/she is board-certified on the application	
- Work history for the past five years	
- Current, adequate malpractice insurance according to your organization's policy	
- History of professional liability claims which resulted in settlements or judgements paid by or on behalf of the practitioner	
Indicate whether each applicant completes a credentialing application that includes a statement by the applicant regarding:	
- lack of present illegal drug use	
- history of loss of license and/or felony convictions	
- history of loss or limitation of privileges or disciplinary activity	
- applicant attests to the correctness and completeness of application	
Prior to making credentialing decision, your organization receives information appropriate to the practitioner's discipline, including:	
- information from the State Board of Licensure or Certification and/or the National Practitioner Data Bank	
- Information about sanctions or limitations on licensure from the appropriate state agency of the Federation of State Medical Boards	
- Review of previous sanction activity by regional Medicare and Medicaid offices	
Licensed behavioral healthcare professional staff from your organization conducts visits to the offices of all potential behavioral healthcare practitioners prior to their acceptance for network inclusion	

b. Does your firm recredential its practitioners at least every two years? If not, please indicate the frequency for recredentialling.

c. In your recerdentialing process, please indicate whether or not the items listed below are completed/reviewed in the process.

RECREDENTIALING PROCESS	YES/NO
Your organization verifies at least the following information from primary souces:	
- current valid state license to practice	
- status of clinical privileges at the institution designated by the behavioral healthcare practitioner as the primary admitting facility, as applicable	
- Graduation from an accredited professional school	

RECREDENTIALING PROCESS	YES/NO
- Board certification (only if the practitioner was due to be recertified)	
- Current, adequate malpractice insurance according to your organization's policy	
- History of professional liability claims which resulted in settlements or judgements paid by or on behalf of the practitioner	
Indicate whether your organization incorporates data from the following sources in its recredentialing/decision making process	
- member complaints	
- clinical record reviews	
- member satisfaction	
- on-site visits conducted by qualified behavioral health professionals from your organization	
Your organization confirms that the practitioner is in good standing with the state and federal regulatory bodies	

b. As above, briefly describe the critical activities, steps and concepts you use for building and maintaining the hospital component of your proposed network.

c. For what period of time are your provider contracts generally negotiated? What type of roll-out agreement is included in your provider contract to assure the Commonwealth that providers will continue to treat the Commonwealth's employees until the end of the plan year (June 30 or September 30 for TLC)?

d. What commitment are you willing to make to assure the Commonwealth that a sufficient number of providers will be available to meet the needs of all Commonwealth employees?

6. Please summarize the major elements of your formal quality assurance program. Describe the activities used to assure the minimal standards are met for day-to-day performance.

7. Describe the technical instruments used to measure and continuously monitor information about processes and procedures.

8. Identify the main quality management initiatives planned for 2004 and 2005.

9. Describe your patient satisfaction surveying/assessment methodology. Provide, as Exhibit 3 following this question, the most recent two years' ***patient satisfaction*** results for the network you are offering. Affirm below that you will comply with paragraph.4.1.6. of this RFP, and conduct annual surveys of Commonwealth of Virginia patient satisfaction.

10. Briefly describe your telephonic automated call distribution (ACD) system capabilities currently available.

11. a. Affirm that you will have a fully trained, dedicated member service function devoted to administration of the Commonwealth's plan. Where will the member service unit reside? What real-time data will be available to the representatives?

b. Attach a list of individuals (i.e., line supervisors and staff) who would be assigned to this member service unit, noting their years of direct experience in member service to large (1,000+ employees) employer plans.

12. Describe your procedures for EAP assessment, referral and follow-up.

13. Describe any special programs you provide to foreign language callers, the elderly and deaf or blind callers.

14. How do you follow up with patients who do not schedule or keep scheduled appointments?

15. Please indicate below the types of problems and issues for which you will provide services.

PROBLEMS/CONCERNS	YES/NO
Depression, anxiety & stress	
Work – related concerns/problems	
Alcohol and/or drug abuse	
Marital and family problems	
Child or adult care issues	
Balancing work and family	
Parenting problems Legal problems	
Financials & debt problems	
Bereavement & other losses	
Career transition issues	
Personal growth & development	
Other – please list other services you offer:	

16. What is the average length of time for a counseling session?

17. Do employees see the same counselor for all sessions?

18. Do you provide training and assistance for managers and supervisors? If yes, please describe.

19. Describe your procedures for providing consultation to managers and supervisors who request help with an employee problem. How will information be handled when it involves serious job infractions?

20. What steps do you take to ensure employer confidentiality is maintained?

21. How will you handle employees that reside outside of your EAP service area?

22. Identify any member service factors not provided in the response to the above questions that you believe make you uniquely qualified to administer the Commonwealth's EAP plan.

23. Provide, under Tab 3, a sample of the employee communication materials that all members are to receive that are intended to meet the requirements of paragraph 6.3 of this RFP.

IV. B. Administrative Capability – EAP - (20 points)

This section asks offerors to describe their customer service standards, results and management process, as well as their administrative/systems capabilities and to affirm standards of performance identified in RFP Section 3.0.

1. Describe your current automated information management system. How long has your current system been fully operational? If more than one system is involved, or the system is split, please provide a chart listing all systems and clearly describe the nature and timing of interfaces.

2. a. Is there an on-line system for logging receipt of treatment plans and matching to authorization periods?

   b. Are treatment plan authorizations generated on-line?

   c. Can authorizations for a specified time period be amended or revised on-line?

   d. Describe other functions your automated information system performs.

   e. Please describe how you will integrate EAP services with managed MISA providers if the Commonwealth were to not utilize your EAP services. What are your interface requirements?

3. a. Affirm below that you can meet all of the ***standards of performance*** detailed in RFP Section 3.0, and provide reports verifying results.

   b. Affirm that you will comply with Schedule of Liquidated Damages described in RFP paragraphs 3.6. and 3.7.

   c. Include below, as Exhibit 4, a complete list of standard reports you can provide to the Commonwealth to demonstrate you are meeting the Standards in the areas noted in question IV.3.a. above. Provide samples as a supplementary attachment (and note location in your proposal here).

4. Affirm that you can meet all of the administrative tasks, specifications and reporting requirements identified in RFP Sections 2.0 and 4.0 and the *Special Terms and Conditions* in Section 8.0. Identify if your firm plans on being able to produce an annual MISA HEDIS (or similar) report for the Commonwealth of Virginia.

6. *Form of Response*, paragraph 6.2., requires submission of benefit descriptions being proposed. Submit, under Tab 2, and affirm that you have complied with Section 6.2 here. ***Be sure*** that clear, distinctive descriptions are provided for both statewide plan benefits and the Local Choice (TLC) options.

7. Provide a brief summary below, and complete descriptions as supplemental attachments, of the following administrative processes and systems (note location of the attachments here). Carefully annotate which processes are automated and which are manual and where the systems/people interfaces occur. If more than one system is involved, or the system is split, please provide: a chart listing all systems and interfaces; location of the systems; and a clear description of the nature and timing of interfaces:

a. ***Member Services***: Describe your processes and controls in providing member services (by phone, letter, in person and/or on-line). Include the functions of: (1) inquiries on benefit and provider information; and (2) handling complaints on providers, administrative/service issues, and/or claim appeals.

b. ***Claim Processing Services***:

(1) Describe how records are maintained, backed up, stored, and retrieved. (Include any provisions for recovery from disaster)

(2) Explain how records are secured and how confidentiality of information is protected

(3). The security of the system, including safeguards against employee embezzlement and theft are very important

(4). Supply a sample EOB with EOB messages.

(5) Include a detailed description of the edits used to ensure the integrity of the data and to guard against duplicate payments

(6) Describe coordination of benefits (COB) procedures

c. ***Membership Accounting Services***: Describe the billing processes for the State plan, and the Local Choice, and COBRA requirements described in RFP Section 8.0 (see Appendices 8 and 9). Be sure to clearly state the services (e.g., number of bills) that are included in your cost proposal versus those at an additional charge. Any additional charges identified must be completely cross-referenced to your response to the cost attachments (i.e., if you describe an optional service or incremental cost to service transactions above a certain amount at $X fee, that service and fee must be included in your cost attachment under an optional label). Timing and reconciliation are critical. Describe the proposed process in detail, including the correction/reconciliation step.

d. ***Systems Development***: Provide the implementation date of the most recent substantive changes to your administration systems. If a future change is contemplated between this date and July 1, 2004, please provide a brief description of the changes and implementation dates.

8. Affirm here that you will meet the claim tape mandatory requirement described in paragraph 2.7.

V. B. Benefit Cost Management, and Administrative Cost - EAP (35 points)

This section asks offerors to describe their capabilities in terms of controlling EAP utilization through case management and requests cost information.

1. Any systems and interfaces involved with the functions addressed in this section that were NOT described and diagramed in your response to Section IV of this questionnaire must be described below (in the form required in Section IV).

2. Describe in detail the information required for processing a provider treatment plan.

3. Describe in detail the process for approving treatment plans.

4. What is your standard turn-around time for approving or disproving a provider treatment plan?

5. How is an emergency inpatient admission defined and how is it certified (during regular hours and during weekends or after hours)? Please include any differences between certifying an admission to in-network and out-of-network facilities.

6. Describe what follow-up action is taken by your company when patients drop out of treatment.

7. Explain your standard procedures for coordinating utilization review with the Commonwealth's MISA and Medical-Surgical plans, including a description of the responsibilities and authority of those plans and your organization.

8. Submit your cost proposal in accordance with the instructions contained in RFP Section 6.0 and Attachment 2.

INSTRUCTIONS FOR COMPLETING ALL SCHEDULES INCLUDED IN THIS CD

1. Schedules to be completed are contained on the CD under the file name **COMMVA.XLS.**

   - **In order for the spreadsheet to work correctly, you need to ENABLE the macros if it asks you.**
   - Immediately after you open the file, do the following steps from the menu bar at the top: File / Save As (put a new disk/CD in your computer) and save the file **with the same name (COMMVA.XLS).** ***Important:*** Make sure you save the file to a new disk/CD and label the diskette for the location you are quoting. **DO NOT PUT MORE THAN ONE FILE ON A DISK/CD ... Remember all files returned should be named COMMVA.XLS; therefore, you will only be able to put one file on a disk/CD.**
   - You will be required to submit the cost proposal both in hard copy (as described in Section 6.0 of the RFP) and on disk/CD (separate disks/CDs for each plan and/or location quoting).

   Note: *It is important that you do not save over the file on the original disk/CD. This original file can be utilized everytime you need to complete a new file for a new location, etc. If you accidentally save over the original file, you will have to pull the file up and delete all of the information you entered in order to complete your next file for data submission.*

2. Click on each sheet tab at the bottom to move from schedule to schedule.

3. You are to enter data only in areas shaded gray on the following worksheets

4. **DO NOT** enter text or spaces in a space which should have a number.
   This may cause you to have errors in the Schedules. If you have errors in your Schedules, you should review prior schedules to make sure you have not entered text or spaces in a space which should have a number.

5. In places where a box is to be checked, point the cursor at the box and a hand will appear. Simply click on the box to place a check in it.

6. Some questions have formulas built-in and will automatically calculate the answers. In these instances, you will not be allowed to change or overwrite the formulas.

7. **DO NOT** change **ANY** formats in the sheets (this includes inserting rows, etc.). Your disk must be returned in the exact same format as when it was sent to you.

Commonwealth of Virginia - ***Instructions for Schedule 2-1 (located immediately following these instructions)*** **Schedule 2-1-A**

(PLEASE NOTE: These schedules apply to RFPs OHB03-2, OHB03-3, OHB03-4 and OHB03-5. Please follow instructions carefully if you are proposing under either RFP.)

You must complete a separate schedule for each plan type (e.g., HMO, PPO, etc.) and each Service Area proposed. You **MUST** propose **BOTH** the State Plan and TLC benefits, and complete **SEPARATE** schedules for each. For deductible, copay and coinsurance variations by plan type, complete Section 12 of the schedule. Detailed instructions are provided below and definitions of the service categories on the form are contained in Schedule 2-1-B. You need only complete portions of the Schedule applicable to the benefits (i.e. Medical/Surgical, Dental, MISA, Prescription Drugs) you are proposing.
Provide your data on the disk/CD and submit the disk/CD and hard copy as directed in RFP Section 5. **DO NOT CHANGE ANY FORMATS IN THE DISK/CD.**

Please clearly identify the specific scope of your offer by completing the information below and Schedule 2-1-C, which details your service areas.

Offeror:		
Coverage Proposed For:	☐ STATE PLAN	☐ TLC
Benefits Proposed:	☐ MISA	☐ EAP
Funding Method:	☐ INSURED	☐ ASO
Plan Type: *(e.g., EPO, HMO, POS, PPO)*		
Service Area:	☐ STATEWIDE	☐ LESS THAN STATEWIDE Region:

(If statewide, label such. If less than statewide, list the general region covered (e.g., Richmond area) and complete Schedule 2-1-C listing each city/county in your service area)

Instructions ***(Please review the instructions carefully and also note well Paragraph 8.5 regarding the administrative 2% surcharge for all plans and the age/sex adjustment for insured plans)***

1. For Sections 1 through 9, complete the requested information by Provider and Setting Type (blocks 1 through 8) for the listed service categories under each Provider/Type heading.

   a. The Service categories are defined in Schedule 2-1-B. Provide the utilization, cost and PMPM information requested in columns (A), (C) and (E), and adjustment factors requested in columns (B) and (D), for each service category you maintain in your reporting systems.

   b. Service categories for which you do not maintain the data as defined may be combined in the "other" category line immediately preceding the Provider/Type sub-total. This may include capitated expenses if the service category expense line is not available. **IF YOU HAVE NO SUB-CATEGORY DATA ELEMENTS, YOU MUST ENTER A ZERO IN THE "OTHER" ROWS FOR THE SPREADSHEET TO PROPERLY TOTAL.**

   c. The contents of the "other" category entries must be specifically defined in Schedule 2-1-D. For Prescription Drugs (Part 6) **THE OTHER LINE MUST INCLUDE THE DISPENSING FEE.**

   d. Please note that the claims data tape specifications require ICD-9, CPT etc. detail that will allow actual claims data to be reported for each contract year. The claims data will be aggregated into the line items requested on Schedule 2-1 and 2-2 and the liquidated damages report refrenced in RFP Section 3.0.

2. Provide the basis of the membership assumption entered in the Total Members block in the upper right corner of Schedule 2-1 by completing the applicable portion of Schedule 2-1-E.

3. For column (A), enter your plan's 1/1/02 - 12/31/02 utilization, unit cost and PMPM results for each service category in the proposed service area. Provide the demographic breakdown of these 2002 results by completing the applicable portion of Schedule 2-1-E.

4. For columns (B) and (D), **assume mature years claims** for both contract years and provide the adjustment factors (expressed to at least two decimal points) that convert your plans experience to that expected for the state plan in the first two contract years. For example:

   - If you expect the State plan's 7/1/04-6/30/05 medical admissions to be 12 percent greater than your plan's 2002 results, enter 1.12 in the block.

   - If the benefits you are proposing are actuarially valued 5% below your 2002 results and annual trend is projected at 6%, enter 1.0925 in the block (i.e. annual trend extended to
     30 months = 1.15 x .95 benefit adjustment factor = 1.0925).

   - If the demographics you expect versus your 2002 plan demographics are estimated to increase medical admissions costs 4%, enter 1.04 in the block.

5. For columns (C) and (E) extend your calculations from columns (A), (B) and (D). For example:

   - If your column (A) Inpatient Medical Admissions Per 1,000 was 35, enter 39.2 (35 x 1.12) in the block.

   - If your column (A) Inpatient Medical Cost Per Admission was $2,000, enter $2,272 ($2,000 x 1.0925 x 1.04).

   - If your column (A) PMPM was $19.10, enter $24.31 ($19.10 x 1.12 x 1.0925 x 1.04).

6. Calculate all applicable claim subtotals and the grand total Line (9). (The spreadsheet should do this automatically)

7. Provide your administrative expense proposals for the assumed membership by completing Section 10.a.(1) through 12b(5) as applicable to the benefits you are proposing. Part 10.a.(14) of the form provides for adjustments based on the scope of your actual versus assumed membership. **You must also complete Administrative Cost Schedule 2-1-F.**

8. Complete Section 11 to summarize your PMPM cost proposals and Per Contract Per Month (PCMP) by benefit offered (i.e., Medical/Surgical, Dental, MISA, Prescription Drug).

9. If your proposal includes more than one design by benefit and/or type (e.g. differences in copays, deductibles, coinsurance), complete Sections 1 through 12 of the report for the single plan design you believe would best meet the objectives of the Commonwealth's RFP. Use Section 12to show the PMPM claim cost impact of your proposed alternative plans.

10. If you are proposing statewide self funded Dental, MISA and/or Prescription Drug benefits under RFP OHB03-3, OHB03-4 or OHB03-5, complete Schedule 2-1 as follows:

    a. Dental: Block 7, parts a. through e. and lines (7) and (9); administration expense sections 10 and 11, and the applicable portions of Section 12, if applicable
    b. MISA and/or EAP: Blocks 1(e), 1(f), 2(e), 2(f), 3(f), 3(g), 4(i), 4(j) and Grand Total line (9); administrative expense sections 10 and 11; the applicable portions of Section 12, if applicable
    c. Prescription Drug: Block 6, parts a. through s.; administrative expense sections 10 and 11; the applicable portions of Section 12 , if applicable; **For Medicare Retiree benefits, complete Schedule 2-1R**.
    d. Schedule 2-1-F: Start-Up and Administrative Cost Schedule

Commonwealth of Virginia

Schedule 2-1

Rate Build-Up Schedule ***(Refer to Schedule 2-1-A for Instructions)***

1. Complete the following exhibit for each plan type for each service area proposed. Instructions and definitions are contained in schedules 2-1-A and B respectively.

2. Enter the number of members you assume in the space to the right. Show the logic for your calculation in Schedule 2-1-E.

Total Members:	

Offeror: ERROR - Not Defined on Sched. 2-1-A | **Plan Type:** ERROR - Not Defined on Sched. 2-1-A | **Service Area:** ERROR - Not Defined On Sched. 2-1-A

			1/1/02-12/31/02 Results			Projected State Plan 7/1/04-6/30/05						Projected State Plan 7/1/05-6/30/06					
			(A)			(B) Adjustment Factors			(C) State Plan Cost			(D) Adjustment Factors			(E) State Plan Cost		
Provider	Type	Service	Utilization Per 1,000 [1]	Unit Cost	PMPM	Utilization	Benefits	Demographic/ Other	Utilization Per 1,000[1]	Unit Cost	Cost PMPM	Utilization	Benefits	Demographic/ Other	Utilization Per 1,000[1]	Unit Cost	Cost PMPM
1. Hospital Inpatient (HIP)	Inpatient	a. Medical															
		b. Organ Transplants															
		c. Other Surgical															
		d. Maternity															
		e. Mental Illiness															
		f. Substance Abuse															
		g. SNF															
		h. Rehab.															
		i. Other															
(1)	***HIP Total***				0						0						0
2. Hospital Outpatient (HOP)	Outpatient	a. Emergency Room															
		b. Medicine															
		c. Surgical															
		d. Maternity															
		e. Mental Illiness															
		f. Substance Abuse															
		g. X-Ray/Imaging															
		h. Lab															
		i. Other Diag. Svcs.															
		j. Therapy Svcs.															
		k. HH/Hospice															
		l. Other															
(2)	***HOP Total***				0						0						0
3. Professional Inpatient (PIP)	Inpatient	a. Inpatient Visits															
		b. Emergency Room															
		c. Medicine															
		d. Surgery, Anesthesia															
		e. Maternity															
		f. Mental Illiness															
		g. Substance Abuse															
		h. Radiology															
		i. Pathology															
		j. Diag. Tests															
		k. Rehab.															
		l. Hearing															
		m. Speech															
		n. Other															
(3)	***PIP Total***				0						0						0

Commonwealth of Virginia

Schedule 2-1

Rate Build-Up Schedule ***(Refer to Schedule 2-1-A for Instructions)***

1. Complete the following exhibit for each plan type for each service area proposed. Instructions and definitions are contained in schedules 2-1-A and B respectively.

2. Enter the number of members you assume in the space to the right. Show the logic for your calculation in Schedule 2-1-E.

Total Members:

Offeror: ERROR - Not Defined on Sched. 2-1-A | **Plan Type:** ERROR - Not Defined on Sched. 2-1-A | **Service Area:** ERROR - Not Defined On Sched. 2-1-A

			1/1/02-12/31/02 Results			Projected State Plan 7/1/04-6/30/05						Projected State Plan 7/1/05-6/30/06					
			(A)			(B) Adjustment Factors			(C) State Plan Cost			(D) Adjustment Factors			(E) State Plan Cost		
Provider	Type	Service	Utilization Per 1,000 (1)	Unit Cost	PMPM	Utilization	Benefits	Demographic/ Other	Utilization Per 1,000(1)	Unit Cost	Cost PMPM	Utilization	Benefits	Demographic/ Other	Utilization Per 1,000(1)	Unit Cost	Cost PMPM
4. Professional Outpatient (POP)	Outpatient	a. Office Visits															
		b. Preventive															
		c. Well Baby Visits															
		d. Emergency Room															
		e. Consults															
		f. Medicine															
		g. Surgery, Anesthesia															
		h. Maternity															
		i. Mental Illiness															
		j. Substance Abuse															
		k. Radiology															
		l. Pathology															
		l. Diag. Tests															
		m. Rehab.															
		n. Chiropractics															
		o. Podiatry															
		p. Vision															
		q. Hearing															
		r. Speech															
		s. Other															
(4)	***POP Total***				0						0						0
5. Ancillary		a. Ambulance/Trans.															
		b. Drugs Administered															
		c. Supplies															
		d. Durable Med. Equip.															
		e. Prosthetics															
		f. Infertility															
		g. Experiemental															
		h. Other															
(5)	***Ancillary Total***				0						0						0
6. Drugs *(excludes Medicare Retiree Drug Component – Complete Schedule 2-1R for Medicare Retiree Rx)*	Tier 1 Retail	a. Brand w/No Generic															
		b. Brand w/Generic															
		c. Generic															
	Tier 2 Retail	d. Brand w/No Generic															
		e. Brand w/Generic															
		f. Generic															
	Tier 3 Retail	g. Brand w/No Generic															
		h. Brand w/Generic															
		i. Generic															
	Tier 1 Mail	j. Brand w/No Generic															
		k. Brand w/Generic															
		l. Generic															

Commonwealth of Virginia

Schedule 2-1

Rate Build-Up Schedule ***(Refer to Schedule 2-1-A for Instructions)***

1. Complete the following exhibit for each plan type for each service area proposed. Instructions and definitions are contained in schedules 2-1-A and B respectively.

2. Enter the number of members you assume in the space to the right. Show the logic for your calculation in Schedule 2-1-E.

Total Members:

Offeror: ERROR - Not Defined on Sched. 2-1-A | **Plan Type:** ERROR - Not Defined on Sched. 2-1-A | **Service Area:** ERROR - Not Defined On Sched. 2-1-A

			1/1/02-12/31/02 Results			Projected State Plan 7/1/04-6/30/05						Projected State Plan 7/1/05-6/30/06					
			(A)			(B) Adjustment Factors			(C) State Plan Cost			(D) Adjustment Factors			(E) State Plan Cost		
Provider	**Type**	**Service**	**Utilization Per 1,000 [1]**	**Unit Cost**	**PMPM**	**Utilization**	**Benefits**	**Demographic/ Other**	**Utilization Per 1,000[1]**	**Unit Cost**	**Cost PMPM**	**Utilization**	**Benefits**	**Demographic/ Other**	**Utilization Per 1,000[1]**	**Unit Cost**	**Cost PMPM**
	Tier 2 Mail	m. Brand w/No Generic															
		n. Brand w/Generic															
		o. Generic															
	Tier 3 Mail	p. Brand w/No Generic															
		q. Brand w/Generic															
		r. Generic															
	Other	s. Other															
(6)	***Drugs Total***				0						0						0
7. Dental		a. Diag/Prev															
		b. Primary (Basic)															
		c. Major															
		d. Orthodontics															
		e. Other															
(7)	***Dental Total***				0						0						0
(8).Vision Plan Total																	
(9).Grand Total Benefit Cost (Sum 1-8)					0						0						0

Commonwealth of Virginia

Offeror:	ERROR - Not Defined on Sched. 2
Plan Type:	ERROR - Not Defined on Sched. 2
Service Area:	ERROR - Not Defined On Sched.

Schedule 2-1
(Expense Build Up)

10. a. Administration Expense Build-Up

Please provide the zero base build-up of your expense charges.
(Note: The 2% Administrative Expense surcharge IS NOT to be included in this schedule. It is to be included in Schedule 2-7 only)

Total Members:	**0**
# of Calls	**0**
# of Claims	**0**
COBRA Enrollment	**0**

Expense Component
Include applicable full-time staff equivalent for each cost line. Include unit factor for all applicable expense categories determined by a factor vs actual expense

	July 1, 2004-June 30, 2005				July 1, 2005-June 30, 2006			
	# FT Equiv. Staff	Unit Factor	# Units	Total Annual Cost	# FT Equiv. Staff	Unit Factor	# Units	Total Annual Cost
(1) Network Administration/Access Fees								
(a) Staffing: Salaries; Benefits; Taxes (for + D14 provider recruitment; maintenance; credentialling; etc)								
(b) Staffing: Salaries; Benefits; Taxes (for other administrative staff)								
(c) Staffing: Salaries; Benefits; Taxes (for management)								
(d) IT								
(e) Property; rent	N/A				N/A			
(f) Office supplies; Equipment	N/A				N/A			
(g) Other (attach detail to this exhibit; specify type of expense & itemize cost build-up for category)								
Sub Total	0		0	$0	0		0	$0
(2) Customer Service Administration								
(a) Staffing: Salaries; Benefits; Taxes (for Cust. Svc. administration)								
(b) Staffing: Salaries; Benefits; Taxes (for any non-Cust. Svc. processing administrative staff)								
(c) Staffing: Salaries; Benefits; Taxes (for management)								
(d) IT								
(e) Property; rent	N/A				N/A			
(f) Office supplies; Equipment	N/A				N/A			
(g) Other (attach detail to this exhibit; specify type of expense and itemize cost build-up for category)								
Sub Total	0		0	$0	0		0	$0
(3) Claim Administration								
(a) Staffing: Salaries; Benefits; Taxes (for claim administration)								
(b) Staffing: Salaries; Benefits; Taxes (for any non-claim processing administrative staff)								
(c) Staffing: Salaries; Benefits; Taxes (for management)								
(d) IT								
(e) Property; rent								
(f) Office supplies; Equipment								
(g) Other (attach detail to this exhibit; specify type of expense and itemize cost build-up for category)								
Sub Total	0		0	$0	0		0	$0
(4) Other Administration (List Functions In Attachment)								
(a) Staffing: Salaries; Benefits; Taxes (for claim administration)								
(b) Staffing: Salaries; Benefits; Taxes (for management)								
(c) IT								
(d) Property; rent								
(e) Office supplies; Equipment								
Sub Total	0		0	$0	0		0	$0
(5) State Premium Tax (if applicable)								

(6) Interest Charge/Credit (if applicable)								
(7) Corporate Overhead								
(8) (a) Profit								
(b) Risk								
(c) Margin								
Sub Total	0		0	$0	0		0	$0
(9) Retained Discounts (Enter total estimated - will subtract when totalling column)								
(10) **Sub-Total Administrative Expense excluding COBRA (sum 1-9)**	0		0	$0	0		0	$0
(10 a.) Convert Your Annual Cost to PMPM Cost (excluding COBRA)								

	# FT Equiv. Staff	Unit Factor	# Units	Total Annual Cost	# FT Equiv. Staff	Unit Factor	# Units	Total Annual Cost
(11) COBRA Administration								
(a) Staffing: Salaries; Benefits; Taxes (for COBRA administration)								
(b) Staffing: Salaries; Benefits; Taxes (for any non-COBRA processing administrative staff)								
(c) Staffing: Salaries; Benefits; Taxes (for management)								
(d) IT								
(e) Property; rent	N/A							
(f) Office supplies; Equipment	N/A							
(g) Other (attach detail to this exhibit; specify type of expense and itemize cost build-up for category)								
(h) Overhead	N/A							
(i) Profit	N/A							
(12) **Sub-Total COBRA Administrative Expense (sum 11a.-11k.)**	0			$0	0			$0
(12 a.) Convert Your Annual Cost to PMPM Cost (COBRA Only)								
(13) **Grand Total Administrative Expense (sum 10 + 12)**	**0**			**$0**	**0**			**$0**
(13 a.) Convert Your Total Annual Cost to PMPM Cost								

(14) Enrollment Adjustment Factor

(Enter the adjustment factor that would apply if actual enrollment differs from assumed at the following thresholds)

(a) + 25%	
(b) + 16-24%	
(c) + 5-15%	
(d) -5 to -15%	
(e) -16 to -24%	
(f) > -25%	

Commonwealth of Virginia

Offeror:	ERROR - Not Defined on Sched. 2-1-A
Plan Type:	ERROR - Not Defined on Sched. 2-1-A
Service Area:	ERROR - Not Defined On Sched. 2-1-A

Schedule 2-1

11. Proposal Cost Summary

a. As indicated in Schedule 2-1-A your funding method proposed is: **ERROR - Not Defined In Schedule 2-1-A**

If more than one funding method proposed, complete separate schedules for Insured and ASO proposals.

b. Complete the table below summarizing your cost proposals -- complete only for benefit option you are proposing.

Cost Summary		1/1/02-12/31/02 Results	Projected State Plan 7/1/04-6/30/05	Projected State Plan 7/1/05-6/30/06
		(A) Your Results PMPM	(C) State Plan Cost PMPM	(E) State Plan Cost PMPM
11. b.(1)	Total MISA/EAP PMPM before Adm Charges	0	0	0
11. b.(2)	MISA/EAP Adm Charges		0	0
11. b.(3)	Total Rate PMPM	0	0	0

c. Complete the table below converting the PMPM Costs reflected above to Per Contract Per Month costs using The Commonwealth's membership/contract factors as follows:

Employee Only:	1.00
Employee + 1:	1.85
Family:	2.70

Per Contract Unit Conversion		1/1/02-12/31/02 Results	Projected State Plan 7/1/04-6/30/05	Projected State Plan 7/1/05-6/30/06
		(A) Your Results Per Contract Per Month	(C) State Plan Cost Per Contract Per Month	(E) State Plan Cost Per Contract Per Month
11. c.(1)	Total MISA/EAP before Adm Charges			
11. c.(2)	MISA/EAP Adm Charges			
11. c.(3)	Total Rate Per Contract Per Month	0	0	0

Commonwealth of Virginia

Offeror:	ERROR - Not Defined on Sched. 2-1-A

Schedule 2-1

As indicated in Schedule 2-1-A your funding method proposed is: **ERROR - Not Defined In Schedule 2-1-A**

If more than one funding method proposed, complete separate schedules for Insured and ASO proposals.

Plan Type:	ERROR - Not Defined on Sched. 2-1-A
Service Area:	ERROR - Not Defined On Sched. 2-1-A

12. Benefits Claim Cost Adjustments - MISA/EAP

If you are proposing more than one benefit design, complete the following information

a. Identify the deductible/copay and coinsurance features of the plan proposed in Sections 1 through 12.

b. Identify the claim cost adjustment(s) to your proposed benefit cost for the plan variations you propose. Note the deductible/copay and coinsurance features in the left column. In the right column, show the benefit adjustment calculation by noting the appropriate PMPM total cost from line (9) above. The benefit adjustment factor expressed to at least two decimal points (i.e., 1.02, .98, etc.) and the benefit alternative PMPM resulting from multiplying line (9) times the factor.

	Alternative Plan Features	Benefit Claim Cost Adjustment					
		(C) State Plan Cost 7/1/04-6/30/05			(E) State Plan Cost 7/1/05-6/30/06		
	12.a. Benefit Proposed Sections 1-12	PMPM Above	Adjustment Factor	Proposed PMPM	PMPM Above	Adjustment Factor	Proposed PMPM
12.b.(1)							
12.b.(2)							
12.b.(3)							
12.b.(4)							
12.b.(5)							

Service Category Definitions

The service categories included in Schedule 2-1 by Professional and setting type are defined on the CD in a MSWord document named SERVDEF.DOC.

Commonwealth of Virginia:

Schedule 2-1-C

Proposed Service Area

Please identify the service area you are proposing by completing the information below.

1. Offeror: ERROR - Not Defined on Sched. 2-1-A

2. Plan Type Proposed: ERROR - Not Defined on Sched. 2-1-A

3. Your proposed service area as indicated on Schedule 2-1-A is:

ERROR - Not Defined In Schedule 2-1-A

4. Indicate below your proposed Service Area. If Statewide, check the All Counties/Cities box below. If less than statewide, check the box next to each county or city in your proposed service area.

☐ All Counties/Cities	☐ Buckingham	☐ Cumberland	☐ Giles	☐ King and Queen	☐ Montgomery	☐ Prince Edward	☐ South Boston	☐ Wise
☐ Accomack	☐ Buena Vista	☐ Danville	☐ Gloucester	☐ King George	☐ Nelson	☐ Prince George	☐ Southampton	☐ Wythe
☐ Albemarle	☐ Campbell	☐ Dickenson	☐ Goochland	☐ King William	☐ New Kent	☐ Prince William	☐ Spotsylvania	☐ York
☐ Alexandria	☐ Caroline	☐ Dinwiddie	☐ Grayson	☐ Lancaster	☐ Newport News	☐ Pulaski	☐ Stafford	☐ Out of State
☐ Amelia	☐ Carroll	☐ Essex	☐ Greene	☐ Lee	☐ Norfolk	☐ Radford	☐ Staunton	
☐ Amherst	☐ Charles City	☐ Fairfax City	☐ Greensville	☐ Loudoun	☐ Northampton	☐ Rappahannock	☐ Suffolk	
☐ Appomattox	☐ Charlotte	☐ Fairfax County	☐ Halifax	☐ Louisa	☐ Northumberland	☐ Richmond City	☐ Surry	
☐ Arlington	☐ Charlottesville	☐ Falls Church	☐ Hampton	☐ Lunenburg	☐ Norton	☐ Richmond County	☐ Sussex	
☐ Augusta	☐ Chesapeake	☐ Fauquier	☐ Hanover	☐ Lynchburg	☐ Nottoway	☐ Roanoke City	☐ Tazewell	
☐ Bath	☐ Chesterfield	☐ Floyd	☐ Harrisonburg	☐ Madison	☐ Orange	☐ Roanoke County	☐ Virginia Beach	
☐ Bedford	☐ Clarke	☐ Fluvanna	☐ Henrico	☐ Manassas	☐ Page	☐ Rockbridge	☐ Warren	
☐ Bland	☐ Clifton Forge	☐ Franklin City	☐ Henry	☐ Manassas Park	☐ Patrick	☐ Rockingham	☐ Washington	
☐ Botetourt	☐ Colonial Heights	☐ Franklin County	☐ Highland	☐ Martinsville	☐ Petersburg	☐ Russell	☐ Waynesboro	
☐ Bristol	☐ Covington	☐ Frederick	☐ Hopewell	☐ Mathews	☐ Pittsylvania	☐ Scott	☐ Westmoreland	
☐ Brunswick	☐ Craig	☐ Fredericksburg	☐ Isle of Wight	☐ Mecklenburg	☐ Portsmouth	☐ Shenandoah	☐ Williamsburg	
☐ Buchanan	☐ Culpeper	☐ Galax	☐ James City	☐ Middlesex	☐ Powhatan	☐ Smyth	☐ Winchester	

5. If the cities and counties listed above do not include the entire contiguous licensed service area, list the excluded cities and counties below.

Commonwealth of Virginia

Schedule 2-1-D

Schedule 2-1 Reported Service Categories

In accordance with instruction 1. of Schedule 2-1-A, define the composition of data included in the "Other" service category lines of your completed Schedule 2-1. Please be specific. For those proposing a Prescription Drug Plan, the other category must include the dispensing fees.

1. Hospital Inpatient "Other" includes:

2. Hospital Outpatient "Other" includes:

3. Professional Inpatient "Other" includes:

4. Professional Outpatient "Other" includes:

5. Ancillary "Other" includes:

6. Drugs "Other" includes: (NOTE: must include dispensing fees)

7. Dental "Other" includes:

Commonwealth of Virginia

Schedule 2-1-E

Membership and Demographics

1. In accordance with instruction 2., in Schedule 2-1-A, provide the basis of your membership assumption for Schedule 2-1. Assume state employee demographics remain constant for both contract years. For example:

   - *The RFP data indicates there are 2,000 state employees residing in our proposed service area.*

   - *For each contract year, we assume state employee enrollment of 30% of these employees (or 600) and that the employee + dependents membership factor is 1.9. Therefore, we project 1,140 members.*

2. Provide the demographic breakdown of your assumed membership in the same format as the data provided in RFP Appendix 2. Attach a summary to this page and be prepared to provide a diskette or CD of the complete breakdown in the Appendix 2 format.

Commonwealth of Virginia

Schedule 2-1-F

Start-Up and Administrative Cost Schedule

Complete the following information related to your Administrative Cost Proposal. Insert this schedule in Tab 5 as instructed in the RFP.

1. Start-Up Cost Budget

If your proposed administration charges do not include start-up costs from the date of award through June 30, 2004, enter the total amount in the box below. Attach a detailed budget specifying tasks, assumptions and component costs to this form.

Total Fixed Price Start-Up Costs:	

2. Propose below a guaranteed interest rate for funds in the operating account or an index which will constitute a minimum guarantee **(applies to ASO offers only)**.

	YEAR 1
a. Guaranteed Interest Rate	
b. Index	

Schedule 2-2

Instructions for Completing Schedule 2-2

Describe the quantitative impact of your provider reimbursement methods as follows:

- Complete the table on the following page. In the appropriate columns:

  ⇒ List the benefit proposed and the plan type (Indemnity, PPO, POS, HMO) in the space at the top of the chart.

  ⇒ In the first gross charge column, aggregate the proportionate distribution of gross charges from the experience data provided in the RFP for the cities/counties included in your proposal service area.

  ⇒ In the second gross charge column, show YOUR projected distribution ON A MATURE YEAR BASIS. If you expect the second contract year to differ from the first, enter your second year distribution in the column labeled "Second Year". *The Commonwealth will allow the second year charge distribution numbers to be adjusted based on first year experience.*

  ⇒ In the right-hand column, show the net impact of <u>YOUR reimbursement methods, claims adjudication, and plan design on YOUR projected charge distribution</u> by projecting the actual claim payment level for the service type. Assume the claims experience and demographics for the Service Areas and plan designs you are quoting. If you expect a different charge distribution in the second contract year, label and enter your net reimbursement in a parallel column.

- Using the Inpatient Facility service type as an example, entries in the appropriate column would be:
  Gross Charge Distribution Amount = 35
  Expected Impact of Reimbursement Method, claims adjudication and application of deductibles, etc. = -10%
  Net Plan Payment = 31.5

- Total the net reimbursements and calculate the plan savings per the formula at the bottom of the table

- Please note, the Commonwealth will use this exhibit to establish the baseline for liquidated damages described in Section 3.0 of the RFP. If awarded a contract, your actual results will be reported via the Claims Data Tape.

Commonwealth of Virginia

Schedule 2-2

Projected Savings Schedule

Describe in Attachment 2-2-A to this schedule your provider reimbursement methods by provider and service type. Include a description for all provider/ service types listed in the table below. If more than one reimbursement method applies, describe each and indicate the proportionate impact of the methods on charges. For example, Inpatient Facility: Discounted Charges (40% of expected gross charges); DRG reimbursement (15%); Per Deim Schedule (25%); Per case (20%).

Instructions are noted on the next page.

Offeror:	ERROR - Not Defined on Sched. 2-1-A	Benefit:	
Plan Type:	ERROR - Not Defined on Sched. 2-1-A	Service Area:	ERROR - Not Defined On Sched. 2-1-A

Service Type	Gross Charge Distribution FIRST YEAR		Net Payment After Your Application of Reimbursement Method	Gross Charge Distrib. SECOND YEAR*
	State Experience	Your Projected		Your Projected*
Inpatient Facility				
Inpatient Professional				
Outpatient Facility				
Outpatient Professional				
- PCP/General				
- Specialist				
Other Medical				
Mental Illness/Substance Abuse (MISA)				
- Inpatient				
- Outpatient				
Prescription Drug				
Dental				
TOTAL	100%	(A) 100%	(B) 0.0%	
(C) Projected Savings = A - B =				

PROVIDER REIMBURSEMENT METHODS **Schedule 2-2-A**

Briefly describe your provider reimbursement methods for the following Provider service types and settings: *(Provide your descriptions via hard copy in your proposal, not on this diskette.)*

1. Inpatient Facility

2. Inpatient Professional

3. Outpatient Facility

4. Outpatient Professional
   a. PCPs (for HMO and POS networks)
   b. Primary/family physicians (for Indemnity Plans and PPO networks)
   c. Specialists
   d. Other Medical (specify)

5. a. Inpatient Mental Illness Professional
   b. Inpatient Substance Abuse Facility

6. a. Inpatient Mental Illness Professional
   b. Inpatient Substance Abuse Professional

7. a. Outpatient Mental Illness Facility
   b. Outpatient Substance Abuse Facility

8. a. Outpatient Mental Illness Professional
   b. Outpatient Substance Abuse Professional

9. Prescription Drug
   a. Brand
   b. Generic
   c. Mail Order

10. Dental
    a. General Dentists
    b. Specialists

Commonwealth of Virginia

Schedule 2-3

Trend History and Projections Schedule

To demonstrate the effectiveness of your cost control methods and the basis of your projected costs for the contract period, complete the table below for each plan type and service area quoted. Express figures as a percentage from previous year. Also, note whether the trends cited are applicable to the service areas proposed, statewide or your entire covered population.

Offeror: ERROR - Not Defined on Sched. 2-1-A

Benefit:

Plan Type: ERROR - Not Defined on Sched. 2-1-A

Service Area: ERROR - Not Defined On Sched. 2-1-A

Trend Scope: ☐ Service Area Proposed ☐ Statewide ☐ Offeror Covered Population
(Check only one box)

	Percent Annual Trend (vs. Previous Year)						
Service Type*	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Inpatient Facility							
Inpatient Professional							
Outpatient Facility							
Outpatient Professional							
Other Medical							
MEDICAL SUB-TOTAL							
Prescription Drug							
Dental							
MISA							

Commonwealth of Virginia

Schedule 2-4

Schedule of Professional Services Allowances

SCHEDULE 2-4 not applicable to MISA/EAP Proposals.

Commonwealth of Virginia

Schedule 2-5

Hospital Inpatient Reimbursement Schedule

SCHEDULE 2-5 not applicable to MISA/EAP Proposals.

Commonwealth of Virginia

Schedule 2-6

Hospital Outpatient Allowances Schedule

SCHEDULE 2-6 not applicable to MISA/EAP Proposals.

Commonwealth of Virginia

Schedule 2-7

Type of Membership Premium Rates

Show below the detailed steps in converting your quoted per-member-per-month cost in Schedule 2-1 to monthly premium rates by line of coverage (i.e., single, employee + 1, family). Complete exhibits for both fully insured and ASO (illustrative) quotes, as applicable. **Please note that this form is the only place you include the 2% surcharge described in paragraph 8.5 of the RFP.**

Note: The Department presently uses the following factors for all plans:

Employee Only:	1.00
Employee + 1:	1.85
Family:	2.70

Offeror: ERROR - Not Defined on Sched. 2-1-A

Service Area: ERROR - Not Defined On Sched. 2-1-A

Plan Type: ERROR - Not Defined on Sched. 2-1-A

MISA		7/1/04 - 6/30/05	7/1/05 - 6/30/06
1. a. PMPM Cost (from Line 11.b. (3) of Sched. 2-1)		$0.00	$0.00
b. Number of members indicated on Schedule 2-1:		0	0
c. Monthly Premium (1.a. x 1.b.):		$0.00	$0.00
2. Attach a hard copy worksheet (do not include on this diskette) detailing the conversion of the above PMPM rates to the quoted line-of-coverage rates below. Include all math, logic and assumptions.			
3. Quoted Monthly Rates (must agree with the products of your attached worksheet) - *excludes 2% surcharge*			
	Enrollment	**7/1/04 - 6/30/05**	**7/1/05 - 6/30/06**
a. Single			
b. Employee + 1			
c. Family			
d. Monthly Total			
4. Quoted Monthly Rates including 2% surcharge			
	Enrollment	**7/1/04 - 6/30/05**	**7/1/05 - 6/30/06**
a. Single			
b. Employee + 1			
c. Family			
d. Monthly Total			

Proposal Checklist

Complete the form below in full, sign in blue ink the completion certification at the bottom of the form, and enclose it following the Cover Sheet as directed in RFP Section 6.0

Offeror:

1.a. Indicate the plan design you have proposed by checking the appropriate blocks:

Plan Scope	**Benefits***			
	Medical	**Dental**	**MISA/EAP****	**Pres. Drug**
(1) Statewide Indemnity Plan				
(2) Statewide EPO, POS/PPO				
(3) Health Maintenance Organizations EPO/HMO				
Note: *Mark any benefit plans quoted on a fully insured basis with an asterisk. ** Note if EAP Only				

1.b. If you have proposed an HMO or EPO with less than statewide coverage, check the block below to affirm that you have met the requirements of RFP OHB03-2, paragraph 2.2. Cite specifics.

Meet requirements of paragraph 2.2 as stated below ❑

2. If you have proposed any network-based plans, affirm by checking the appropriate blocks below, that you meet the Mandatory Qualifications stated in RFP paragraph 2.7 or 2.8 (varies by RFP). Your affirmation will also declare your intent to submit appropriate documentation as may be required to demonstrate these qualifications are met throughout the contract period.

Mandatory Qualifications for Contractors	**Meet Standard (✓)**
1. Can demonstrate sufficient access	
2. Will produce approved Member Satisfaction Survey	
3. Will provide toll-free number by April 1, 2004	
4. Will provide web site by April 1, 2004	
5. Will provide paid claims test tape by September 1, 2003	

3. Affirm below that you are in agreement with the Standards of Performance specified in RFP Section 3, including the Schedule of Liquidated damages, and will provide the requested documentation and claims tapes substantiating your performance.

Statement	Agreement (✓)
We agree to adhere to the specified Standards of Performance, Schedule of Liquidated Damages, and claims tape documentation requirements	

4. Affirm, by checking the appropriate block below, that you have completed and submitted all of the following required proposal components as required in RFP Section 6.

Proposal Component	Completed and Submitted (✓)
a. Cover Sheet, original signed in blue ink	
b. This Proposal Checklist and Questionnaire, original signed in blue ink	
c. Confidential/Proprietary information statement and affected page marking	
d. Tab 1 Redline RFP noting demurrals	
e. Tab 2 Benefits Description	
f. Tab 3 Benefits Brochure	
g. Tab 4 Questionnaire	
h. All Tab 5 Cost Proposal schedules in Attachment 2 and certified audit report as requested in RFP Section 6	
i. Tab 6 Small, Women, and Minority-Owned Business detail (Exhibit TWO)	

_____ _____

(Signature) (Date)

_____ _____

(Name) (Title)

_____

(Company)

Attachment 3

Report Formats

The general form and contents of each contractor submitted report are outlined below. It is not the intent of the Department to require special designed reports if the Contractor has a standard report format that will satisfy the Department's needs for oversight of the various programs. However, the Department reserves the right to require a special report design if the standard reports are not satisfactory, in the Department's opinion. Offeror shall submit a sample report with the final format and details to be determined during the negotiation process. The primary reports are addressed below, however the Offeror should submit a sample of any requested report, whether identified below or not.

1. Weekly Claims Report

   A. Cover Letter – Each report provides Cover Charges broken by the following categories: (a) State Employees, (b) State Medicare for Drug Only, (c) TLC Government, (d) TLC Schools, and (e) Total column. Each column will reflect any applicable discounts on a separate line and show net charges by category. This will serve as the Contractor's invoice and the total of the net charges will be the amount due the Contractor.

   B. An Excel spread sheet for each category will provide a detail of covered charges broken by type of charge. Examples can be: Inpatient, Hospital, Vision, EAP, Mail order, etc. The spreadsheet shall provide a Plan Year-To-Date column followed by month-to-date column and a separate column for each week of the current month.

2. Administrative Fee Report – Monthly Invoice

   A. Cover Letter – Each report provides Monthly Administrative Fees broken by the following categories: (a) State Employees, (b) State Medicare for Drug Only, (c) TLC Government, (d) TLC Schools, and (e) Total column. Any pre-approved charges or credits will be shown under each category and added to or subtracted from the categories fees. This will serve as the Contractor's invoice and the total of the net charges will be the amount due the Contractor.

B. Support Documentation

a. Enrollment summary – For each category in A, the enrollment by plan within that category will be provided along with the applicable fee singularly and in total for all units within the plan. A Y-T-D column shall also be provided for each enrollment line. The total for all units within a category shall be the amount invoiced in A above.

NOTE: THE DEPARTMENT WILL AUDIT EACH MONTH'S REPORTED ENROLLMENT BY THE CONTRACTOR. A VARIANCE IN EXCESS OF 0.5% (1/2 OF A PERCENT) FROM THE ENROLLMENT SHOWN ON BES MAY RESULT IN A DELAY IN PAYMENT OF THE INVOICE UNTIL THE DISCREPENCY IS RESOLVED. SEE LIQUIDATED DAMAGES SCHEDULE AS PERTAINS TO ELIGIBILITY FILES NOT PICKED UP TIMELY.

b. Pre Approved Charges or Credits – A schedule of any charges or credits will be included by category as provided in A above. Support documentation for such charges/credits must be provided.

3. TLC Monthly Income Report

This report pertains to the ASO contractor for medical/surgical benefits only (See paragraph 4.1.6 in RFP OHB03-2). The report shows the premium income received from each local employer by plan and in total, with an indication of employer groups in default. The report is to be prepared in MS Excel format and E-mailed on the 8th day after the close of the month.

4. Monthly Service Report

This report shall be in Excel format and submitted electronically to the Department within 15 days of the end of each month. The report shall be contained one page, if possible, and address all Standards of Performance, Section 3.0, except for the annual premium projections due by September 15th.

The first column on the spreadsheet shall identify the items being reported and have headings with specific detail line items. Examples of headings, if applicable, would be: network, participants, customer service call statistics, claims activities, cycle time, inventory, accuracy rates, COB savings, claims dollars paid (by plan and by enrollee), EAP services, and pharmacy scripts by tier. Additional columns should show standards, if applicable, YTD statistics, and most recent two quarters of activity broken by month.

5. Monthly/Quarterly Utilization Management Report

This report shall be in Excel format and submitted electronically to the Department within 15 days of the end of each month/quarter. The report shall be contained one page, if possible. The purpose of this report is to disclose the Contractor's assessment of its utilization management activities, including admission review, concurrent review and case management.

The first column on the spreadsheet shall identify the items being reported and have headings with specific detail line items. The additional columns should show the activity YTD, the current month, average of the past 3 months, and average of past 12 months.

In addition to the utilization report described above, the Contractor shall submit support reports that allow the Department to monitor utilization by the specific product covered. Examples of, but not limited to, such reports are:

a. Medical and MISA - Large inpatient claims expected to exceed $100,000 with amount paid to date and expected total

b. Pharmacy – Top 10 drugs processed by quantity and dollar volume.

c. EAP – Services requested and provided by type.

d. Interventions provided – Type and quantity for disease and pharmacy management.

6. Extended Coverage (COBRA) Transactions and Enrollment File

This report shall be in Excel format and submitted electronically to the Department within 10 days of the end of each month. The primary purposes of the report are (1) to report all changes (adds, change in membership, and terminations) to the previous month's Extended Coverage enrollment, and (2) to provide a file denoting the current Extended Coverage enrollment.

The file shall at a minimum contain the enrollees name, identification number; type, reason, and date of change; and current status.

Commonwealth of Virginia
Claims Database
Data Definitions
July 1, 2003

Facility Provider Type

01: Hospital
02: Skilled Nursing Facility
03: Home Health Agency
04: Physical Therapy Clinic
05: Outpatient Clinic
06: Health Maintenance Organization
07: Visiting Nurses Association
08: Private Laboratory
09: Alcohol Rehabilitation Facility
10: Ambulatory Surgical Facility Level I
11: Ambulatory Surgical Facility Level II
12: Ambulatory Surgical Facility Level III
13: Ambulatory Surgical Facility Level IV
14: Partial Day Psychiatric Facility
15: Other Facility
16: Urgent Care Center

Professional Provider Type

31: Medical Doctor (MD)
32: Ambulatory Surgery Physician: High Level
33: Ambulatory Surgery Physician: Low Level
34: Ambulatory Surgery Provider
35: Clinical Nurse Specialist (CNS)
36: Doctor of Osteopath (DO)
37: Dentist (DDS/DMD)
38: Doctor of Podiatry (DPM)
39: Licensed Psychologist (LP)
40: Certified Registered Nurse Anesthetist (CRNA)
41: Consultant
42: Medical Laboratory
43: Christian Science Nurse
44: Hospital Outpatient Endorsement
45: Physical Therapist
46: Occupational Therapist
47: Speech Therapist
48: Optician
49: Nurse Midwife
50: Hospital Emergency Room Physician
51: Licensed Professional Counselor (LPC)
52: Durable Medical Equipment Supplier (DME)
53: Chiropractor (DC)
54: Optometrist
55: Licensed Clinical Psychologist (LCP)
56: Licensed Clinical Social Worker (LCSW)

57: Audiologist
58: School Psychologist
59: Home Health Agency
60: I.V. Therapy
61: Other Professional Provider

Pharmacy Provider Type

91: Retail
93: Mail Order Only

Provider Specialty (Professional Only)

01: Addictionology
02: Administration/Preventive Medicine
03: Adolescent Medicine
04: Allergy
05: Ambulance Services
06: Anesthesiology (Osteopath)
07: Anesthesiology
08: Audiology
09: Cardiac Surgery
10: Cardiology
11: Cardiovascular Disease
12: Child Psychiatry
13: Chiropractor
14: Christian Science Nurse
15: Clinical Nurse Specialist
16: Clinical Psychology
17: Colon/Rectal Surgery
18: Critical Care
19: CRNA
20: Dermatology (Osteopath)
21: Dermatology
22: Dermatopathology
23: Diagnostic Radiology
24: Diagnostic Roentgenology
25: Durable Medical Equipment
26: Ear Nose & Throat
27: Emergency Medicine
28: Endocrinology
29: Endodontist (Dentist)
30: Eye, Ear, Nose & Throat (Osteopath)
31: Family Practice (Osteopath)
32: Family Practice
33: Forensic Pathology
34: Gastroenterology
35: General Anesthesia (Dentist)
36: General Practice (Dentist)
37: General Practice (M.D.)

38: General Practice (Osteopath)
39: General Surgery
40: General Surgery (Osteopath)
41: Genetics Metabolism
42: Geriatrics Medicine
43: Gynecological Oncology
44: Gynecology (Osteopath)
45: Gynecology
46: Hand Surgery
47: Head & Neck Surgery
48: Hematology/Oncology
49: Hepatology
50: Home Health Agency (Professional Only)
51: Hospital
52: Hospital Outpatient Endorsement
53: Hospital Psychiatric Care
54: Hospital Reference Lab
55: Immunology
56: Independent Laboratory
57: Infectious Disease
58: Internal Medicine (Osteopath)
59: Internal Medicine
60: IV Therapy
61: Licensed Professional Counselor
62: Licensed Psychologist
63: Manipulative Therapy
64: Maternal/Fetal Medicine
65: Maxillo-Facial Surgery (Dentist)
66: Medical Genetics
67: Multi Specialty Clinic
68: Neonatal/Perinatal Medicine
69: Nephrology
70: Neurological Surgery
71: Neurology
72: Neurotology
73: Nuclear Medicine
74: Nurse Midwife
75: Nurse Practitioner
76: Obstetrics (Osteopath)
77: Obstetrics
78: Obstetrics/Gynecology
79: Occupational Therapy
80: Ophthalmology
81: Optician
82: Optometrist
83: Oral Pathologist
84: Oral Surgery (Dentist)
85: Orthodontist (Dentist)
86: Orthopedics
87: Orthopedic Surgery
88: Orthopedic Surgery (Osteopath)
89: Other (Dentist)

90: Otology
91: Pain management
92: Pathology (Osteopath)
93: Pathology
94: Pediatric Allergy
95: Pediatric Anesthesiology
96: Pediatric Cardiac Surgery
97: Pediatric Cardiology
98: Pediatric Cardiovascular Disease
99: Pediatric Critical Care
A0: Pediatric Dentistry
A1: Pediatric Dermatology
A2: Pediatric Ear Nose & Throat
A3: Pediatric Emergency Medicine
A4: Pediatric Endocrinology
A5: Pediatric Gastroenterology
A6: Pediatric Hematology/Oncology
A7: Pediatric Hepatology
A8: Pediatric Immunology
A9: Pediatric Infectious Disease
B0: Pediatric Internal Medicine
B1: Pediatric Nephrology
B2: Pediatric Neurological Surgery
B3: Pediatric Neurology
B4: Pediatric Ophthalmology
B5: Pediatric Orthopedic Surgery
B6: Pediatric Orthopedics
B7: Pediatric Pathology
B8: Pediatric Physical Medicine & Rehabilitation
B9: Pediatric Plastic Surgery
C0: Pediatric Pulmonary Medicine
C1: Pediatric Radiology
C2: Pediatric Rheumatology
C3: Pediatric Surgery
C4: Pediatric Surgical Oncology
C5: Pediatric Trauma
C6: Pediatric Urology
C7: Pediatrics (Osteopath)
C8: Pediatrics
C9: Periodontist (Dentist)
D0: Peripheral Vascular
D4: Physical Medicine & Rehabilitation
D5: Physical Therapy
D6: Plastic Surgery
D7: Podiatry
D8: Proctology
D9: Prosthodontist Dentist)
E0: Psychiatry
E1: Psychiatry/Neurology
E2: Public Health
E3: Pulmonary Diseases
E4: Radiation Oncology

E5: Radiation Therapy
E6: Radiology
E7: Reproductive Endocrinology
E8: Rheumatology
E9: Roentgenology/Radiology
F0: School Psychologist
F1: Skilled Nursing Facilities
F2: Social Worker
F3: Speech Pathology
F4: Sports Medicine
F5: Surgical Oncology
F6: Surgical Pathology
F7: Therapeutic Radiology
F8: Thoracic Surgery
F9: Transplant Surgery
G0: Trauma Surgery
G1: Urgent Care Provider
G2: Urology
G3: Vascular Surgery
XX: Specialty Unknown

Place of Treatment Codes

00: Other Unlisted Licensed Facility
0G: Hemophilia Treatment Center
10: Inpatient Hospital
1S: Hospital Affiliated Hospice
1Z: Inpatient Rehabilitation Hospital
20: Outpatient Hospital
2E: Hospital Emergency Room
2F: Hospital Based Ambulatory Surgery Facility
2S: Outpatient Hospital Bases Hospice
2Z: Outpatient Rehabilitation Hospital
30: Providers Office
3S: Hospice Service Rendered in Providers Office
40: Patient's Home
4S: Hospice Service Rendered in Patient's Home
51: Inpatient Psychiatric Facility
52: Outpatient Psychiatric Facility
53: Day/Night Partial Day Psychiatric Facility
54: Psychiatric or Substance Abuse Night Facility
55: Residential Substance Abuse Treatment Facility
56: Outpatient Substance Abuse Treatment Facility
57: Psychiatric Halfway House
58: Hospital, Partial Hospitalization
60: Independent Clinical Lab
70: Nursing Home
80: Skilled Nursing Facility/Extended Care Facility
90: Ground Ambulance
9A: Air Ambulance

9C: Sea Ambulance
B0: Free standing Ambulatory Medical Facility
BD: Free-standing dialysis facility
BF: Free standing Ambulatory Surgery Facility
BM: Free standing Alternate Birth Center
BR: Free standing Cardiac Rehabilitation Facility
BS: Free standing Hospice Facility
BT: Free standing Substance Abuse Facility - Inpatient
BU: Free standing Substance Abuse Facility – Outpatient
BV: Free standing Substance Abuse Facility – Partial Hospitalization
C0: Pharmacy
C1: Urgent Care Center

Type of Service Codes

000: Unknown Type of Service
200: Surgery
2M0: Oral Surgery
2P0: Surgery/Professional Component
2R0: Donor Surgery
2R1: Surgery/Transplant Recipient
2T0: Assistant at Surgery
2U0: Surgery/Supplemental Accident
2V0: Surgery/Technical Component
300: Maternity
3Q0: Elective Abortion
400: Anesthesia
4R0: Anesthesia/Donor Surgery
4R1: Anesthesia/Transplant Surgery
4U0: Anesthesia/Supplemental Accident
500: Diagnostic Radiology/Nuclear Medicine & Ultrasound
530: Diagnostic Radiology/Maternity Care
5A0: Diagnostic Radiology/Emergency Medical Care
5I0: Diagnostic Radiology/Digital Subtraction Angiography
5K0: Diagnostic Radiology/Pre-Admission Testing
5N0: Diagnostic Radiology/Emergency Medical Care
5P0: Diagnostic Radiology/Professional Component
5R0: Diagnostic Radiology/Donor Surgery
5R1: Diagnostic Radiology/Transplant Surgery
5U0: Diagnostic Radiology/Supplemental Accident
5V0: Diagnostic Radiology/Technical Component
600: Medical Care
6A0: Emergency Medical Care
6B0: Concurrent Care
6J0: Medical Care/Home Health Care Program
6K0: Medical Care/Pre-Admission Testing
6L0: Medical Care/EKG, EEG & Other Electronic Diagnostic Procedures
6N0: Medical Care/Emergency Accident Care
6P0: Medical Care/Professional Component
6R0: Medical Care/Donor Surgery
6R1: Medical Care/Transplant Recipient

6S0: Medical Care/Psychiatric Care
6U0: Medical Care/Supplemental Accident
6V0: Medical Care/Technical Component
6W0: Medical Care/Second Surgical Opinion
600: Medical Care
6X0: Alcohol Rehabilitation
6X1: Alcohol And/Or Drug Detoxification
6Y0: Medical Care/Consultation
6Z0: Drug Rehabilitation
740: Hemodialysis
750: Hyperthermia Therapy
7C0: Chemotherapy
7D0: Physical Medicine (Therapy)
7E0: Therapeutic Radiology
7F0: Occupational Therapy
7G0: Speech Therapy
7H0: Respiratory Therapy
7P0: Therapeutic Radiology/Professional Component
7V0: Therapeutic Radiology/Technical Component
800: Diagnostic Pathology (Laboratory)
830: Diagnostic Pathology/Maternity Care
8A0: Diagnostic Pathology/Emergency Medical Care
8K0: Diagnostic Pathology/Pre-Admission Testing
8N0: Diagnostic Pathology/Emergency Accident Care
8P0: Diagnostic Pathology/Professional Component
8R0: Diagnostic Pathology/Donor Surgery
8R1: Diagnostic Pathology/Transplant Recipient
8U0: Diagnostic Pathology/Supplemental Accident
8V0: Diagnostic Pathology/Technical Component
9A0: Well Baby/Well Child Care
9B0: Whole Blood, Blood Derivatives, Administration & Processing
9C0: Hospice Care Program
9D0: Dental Care
9F0: Ambulance
9G0: Physical Accessories, Purchase
9H0: Physical Accessories, Rental
9J0: Home Health Care Program
9K0: Prescription Drug Program
9L0: Prescription Drugs and Medicine
9M0: Vision Care Program
9N0: Visiting Nurse Services
9P0: Private Duty Nursing
9R0: Transportation of Surgical/Harvesting Team & Donor Organ
9R1: Recipient Transportation & Lodging
9T0: Individual Benefits Management
9V0: Hearing Care Program
L00: Not Medically Necessary Admission
L10: Admission Primarily Diagnostic Studies (Diagnostic Admission)
L20: Admission Primarily for Custodial/Domiciliary Care
L30: Admission Primarily for Physical Therapy

Commonwealth of Virginia
Claims Database
Claims File
Data Specifications
July 1, 2003

Transmittal Frequency:	**Same frequency as billing to Commonwealth. For example, a Carrier providing both ASO and Insured plans, might provide the ASO claims weekly and the Insured claims monthly.**
Medium:	**(1) CDROM. ASCII data. PC formatted records, i.e. CR, LF at end of each record.** **(2) Same as (1). Data compressed with PKZIP.** **-or-** **(3) Same as (1) except transmitted electronically (assuming compatible hardware and software).**
Data Requirements:	**All dollar amounts should have leading sign, 2 decimal places and and implied decimal point. Field can be zero or blank filled. E.g. a 9 byte field containing the value ($100.00) could be coded either 'bbb-10000' or '–00010000'. Positive amounts can either have '+' sign or be unsigned. $100.00 can be represented as '+00010000', '000010000', 'bbb+10000', or 'bbbb10000'.** **All dates should be provided CCYYMMDD where CC denotes Century, YY denotes year, MM denotes Month, and DD denotes Day. E.g. July 11, 1946 is '19460711'. If date is Not Applicable, field should be coded '00000000'.** **File will consist of 5 type records: Header, Facility, Professional (including Dental), Pharmacy, and Trailer. There will be 1 Header record as the first record on the file, 1 Trailer record at the end of the file, and the remaining records between the Header and Trailer records. Each of the Professional and Pharmacy records should correspond to an item (line) of a bill, where a bill can be represented as multiple records with the same claim number, the same provider, and the same processing date. For Facility claims, each record should correspond to the aggregate claim for the Facility; any breakdown will be provided within the aggregate record.** **The file should contain all claims processed on behalf of the Commonwealth during the transmittal period, regardless of the funding type or billing arrangement. Denied claims and adjustments to denied claims should be included on the file. Where capitated arrangements are in place, the claims file should still contain the underlying claims. Dollar amounts for capitated claims should be completed to the level of detail for which data is available.**

Record type	Field Name	Size	Data type	Comments
Header	Record Type	1	Char	Value = 'A'
Header	Carrier Code	3	Char	To be assigned by the Commonwealth of Virginia (COV)
Header	File type	10	Char	Value = "CLAIM"
Header	Earliest processing date	8	Date	Claim Processed Date
Header	Latest processing date	8	Date	Claim Processed Date
Header	Filler	*670*	Char	Value = Spaces
	Record Length	*700*		
Prof	Record Type	1	Char	Value = 'P'
Prof	Carrier Code	3	Char	To be defined by COV
Prof	Covered Group	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
Prof	Plan Code	4	Char	To be defined by COV
Prof	Contract Number (Subscriber SSN)	9	Char	No '-'.
Prof	Subscriber Birth Date	8	Date	
Prof	Subscriber Sex	1	Char	"M" : Male "F" : Female
Prof	Subscriber Zip Code	10	Char	
Prof	Subscriber Agency/ TLC Group	3	Char	For State, Agency Code from BES feed. If not active, COV may provide desired code(s) to denote COBRA, early Retiree, Medicare Retiree. For TLC, School or Government Group Identifier.
Prof	Patient SSN	9	Char	Optional. No '-'.
Prof	Patient Last Name	20	Char	
Prof	Patient First Name	15	Char	
Prof	Patient Birth Date	8	Date	
Prof	Patient Relationship to Subscriber	1	Char	"E" : Self "S" : Spouse "C" : Child "O" : Other
Prof	Patient Sex	1	Char	"M" : Male "F" : Female
Prof	Patient Zip Code	10	Char	
Prof	Claim Number	20	Char	
Prof	Claim Number Suffix	2	Char	Optional. Can be used to differentiate multiple items (lines) on claim.
Prof	Claim Incurred Date	8	Date	
Prof	Claim Received Date	8	Date	
Prof	Claim Adjudicated Date	8	Date	
Prof	Claim Processed Date	8	Date	
Prof	Claim Check Date	8	Date	Date on the check when issued.
Prof	Claim Paid Date	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Prof	Claim Disposition	1	Char	"O" : Original Claim

				"P" : Positive Adjustment "N" : Negative Adjustment
Prof	Optional Benefit Utilization (Expanded Benefit – Key Advantage, Key Share or COVA Care)	1	Char	"Y" : Used expanded benefit, i.e. claim would not have been paid under Basic Coverage. "N" : Did not use expanded benefit or expanded benefit option not part of this plan design
Prof	Optional Benefit Utilization (Buy-up Utilization)	1	Char	For claims prior to 7/1/1998 only. N or space: Buyup non applicable A : 80% Buy-up Utilized B : 85% Buy-up Utilized C : 90% Buy-up Utilized D : 95% Buy-up Utilized
Prof	Optional Benefit Utilization (COVA Care out of network)	1	Char	Y – Out of Network Benefit Applies N – Not COVA Care or COVA Care And Out of Network Benefit N/A
Prof	Claim Approved/Denied	1	Char	Space or "A" – Approved "D" – Denied (Total Charges = Not Covered Charges)
Prof	Capitated/Non-Capitated	1	Char	Space or "N" – Non-capitated "C" - Capitated
Prof	Inpatient/Outpatient	1	Char	"I" : Inpatient "O" : Outpatient
Prof	Place of Treatment	5	Char	See attached list of valid codes.
Prof	Type of Service	5	Char	See attached list of valid codes.
Prof	Claim Primary Payer	1	Char	"T" : This carrier is primary "M" : Medicare is primary "O" : Other carrier is primary
Prof	Claim Secondary Payer	1	Char	"T" : This carrier is secondary "M" : Medicare is secondary "O" : Other carrier is secondary "N" : No secondary payer "U" : Secondary payer not verified
Prof	Claim Tertiary Payer	1	Char	"T" : This carrier is tertiary "O" : Other carrier is tertiary "N" : No tertiary payer "U" : Tertiary payer not verified
Prof	Principal HCPCS Code	5	Char	Actual Code or "N/A". HCPCS includes Level 1 (CPT), Level 2
Prof	HCPCS Code Modifier	5	Char	Modifier or blank
Prof	Additional HCPCS Code	5	Char	Actual Code or "N/A"
Prof	HCPCS Code Modifier	5	Char	Modifier or blank
Prof	CDT-2 Code	5	Char	American Dental Association code. Actual Code or "N/A".
Prof	CDT-2 Level	1	Char	N – Not applicable, no CDT-2 code 1 – Dental Claim processed as Block 1 (Diagnostic and Preventive) 2 – Dental Claim processed as Block 2 (Primary) 3 – Dental Claim processed as Block 3 (Major) 4 – Dental Claim processed as Block 4

				(Orthodontic) M – Dental Claim paid under medical plan.
Prof	ICD-9 Principal Diagnosis Code	6	Char	Actual Code with "." or "N/A". Required.
Prof	ICD-9 Secondary Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Prof	Provider ID type	2	Char	FI – Federal Taxpayer's ID Number PC – Provider Commercial Number UP – Unique Physician ID Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval) COV plans to require HCFA ID if the National Provider ID is mandated for use.
Prof	Provider ID	15	Char	
Prof	Provider Name	50	Char	
Prof	Provider Type	2	Char	See attached list of valid codes.
Prof	Provider Specialty	2	Char	See attached list of valid codes.
Prof	Provider Location – City	20	Char	
Prof	Provider Location – State	2	Char	
Prof	Provider Location – Zip Code	10	Char	
Prof	Provider Referral	1	Char	"P" : Provider is PCP "R" : PCP referral "S" : Self referral "T" Specialist referral
Prof	Provider In/Out Network	1	Char	"I" : Provider in Network "P" : Participating Provider not in Network "N" : Non-participating Provider
Prof	Provider Contract Level	10	Char	"HMO" "HMO POS" "EPO" "POS PPO" "PPO" "PHO" "INDEMNITY"
Prof	Total Charges	10	Amount	
Prof	Non-benefit Charges not covered	10	Amount	e.g. convenience items
Prof	Benefit Charges not covered	10	Amount	e.g. a benefit not covered by COV's plan.
Prof	Discount	10	Amount	If Schedule of Allowance is less than Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not covered, Discount = Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered – Schedule of Allowance. Otherwise, Discount is zero.
Prof	Schedule of Allowance	10	Amount	Applicable to this procedure, provider, and to the COV.
Prof	Eligible Charges	10	Amount	Should be lesser of Schedule of Allowance and Total Charges – Non-benefit Charges

				Not Covered – Benefit Charges Not Covered.
Prof	Deductible	10	Amount	
Prof	Coinsurance	10	Amount	Copayment is stored in separate field
Prof	COB	10	Amount	
Prof	Net Payment After Application of Reimbursement Method	10	Amount	Expected relationship of amounts is Net Payment After Application of Reimbursement Method + COB + Copayment + Coinsurance + Deductible = Eligible Charge.
Prof	Internal Claim ID	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.
Prof	Copayment	10	Amount	Copayment separate from Coinsurance
Prof	Contract Type	1	Char	Blank or 'A' – Active 'C' – Cobra 'R' - Retiree
Prof	Filler	*222*	Char	Spaces
	Record length	*700*		
Fac	Record Type	1	Char	Value = 'F'
Fac	Carrier Code	3	Char	To be defined by COV
Fac	Covered Group	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
Fac	Plan Code	4	Char	To be defined by COV
Fac	Contract Number (Subscriber SSN)	9	Char	No '-'
Fac	Subscriber Birth Date	8	Date	
Fac	Subscriber Sex	1	Char	"M" : Male "F" : Female
Fac	Subscriber Zip Code	10	Char	
Fac	Subscriber Agency/ TLC Group	3	Char	For State, Agency Code from BES feed. If not active, COV may provide desired code(s) to denote COBRA, early Retiree, Medicare Retiree. For TLC, School or Government Group Identifier.
Fac	Patient SSN	9	Char	Optional. No '-'.
Fac	Patient Last Name	20	Char	
Fac	Patient First Name	15	Char	
Fac	Patient Birth Date	8	Date	
Fac	Patient Relationship to Subscriber	1	Char	"E" : Self "S" : Spouse "C" : Child "O" : Other
Fac	Patient Sex	1	Char	"M" : Male "F" : Female
Fac	Patient Zip Code	10	Char	
Fac	Claim Number	20	Char	
Fac	Claim Number Suffix	2	Char	Optional. Can be used to differentiate

				multiple items (lines) on claim.
Fac	Claim Incurred Date - Begin	8	Date	
Fac	Claim Incurred Date – End	8	Date	
Fac	Number of Days Covered	5	Num	Signed. Right Justified. 0 Decimal places. Should be negative for negative adjustment.
Fac	Claim Received Date	8	Date	
Fac	Claim Adjudicated Date	8	Date	
Fac	Claim Processed Date	8	Date	
Fac	Claim Check Date	8	Date	Date on the check when issued.
Fac	Claim Paid Date	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Fac	Claim Disposition	1	Char	"O" : Original Claim "P" : Positive Adjustment "N" : Negative Adjustment
Fac	Optional Benefit Utilization (Expanded Benefit – Key Advantage, Key Share or COVA Care)	1	Char	"Y" : Used expanded benefit, i.e. claim would not have been paid under Basic Coverage. "N" : Did not use expanded benefit or expanded benefit option not part of this plan design
Fac	Optional Benefit Utilization (Buy-up Utilization)	1	Char	For claims prior to 7/1/1998 only. N or space: Buyup non applicable A : 80% Buy-up Utilized B : 85% Buy-up Utilized C : 90% Buy-up Utilized D : 95% Buy-up Utilized
Fac	Optional Benefit Utilization (COVA Care out of network)	1	Char	Y – Out of Network Benefit Applies N – Not COVA Care or COVA Care And Out of Network Benefit N/A
Fac	Claim Approved/Denied	1	Char	Space or "A" – Approved "D" – Denied (Total Charges = Not Covered Charges)
Fac	Capitated/Non-Capitated	1	Char	Space or "N" – Non-capitated "C" - Capitated
Fac	Inpatient/Outpatient	1	Char	"I" : Inpatient "O" : Outpatient
Fac	Place of Treatment	5	Char	See attached list of valid codes.
Fac	Type of Service	5	Char	See attached list of valid codes.
Fac	Claim Primary Payer	1	Char	"T" : This carrier is primary "M" : Medicare is primary "O" : Other carrier is primary
Fac	Claim Secondary Payer	1	Char	"T" : This carrier is secondary "M" : Medicare is secondary "O" : Other carrier is secondary "N" : No secondary payer "U" : Secondary payer not verified
Fac	Claim Tertiary Payer	1	Char	"T" : This carrier is tertiary "O" : Other carrier is tertiary "N" : No tertiary payer "U" : Tertiary payer not verified
Fac	DRG Code	3	Char	For inpatient facility claims, carrier should

				provide DRG Code, ICD-9 Principal Diagnosis Code, and ICD-9 Principal Procedure Code. If carrier cannot provide DRG Code, then carrier must provide all ICD-9 diagnosis and procedure codes.
Fac	ICD-9 Principal Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Other Diagnosis Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Principal Procedure Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with "." or "N/A"
Fac	ICD-9 Additional Procedure Code	6	Char	Actual Code with "." or "N/A"
Fac	Ambulatory Patient Classsification (APC) Group Number	5	Char	For outpatient facility claims, carrier should provide APC Group Number. If carrier cannot provide APC Group Number, then carrier must provide all Uniform Billing (UB-92) Revenue Codes coded on the claim.
Fac	Ambulatory Surgical Center (ASC) Group	5	Char	Blank or 1-8 as appropriate.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual. Fill in all UB-92 codes for which non-zero $ were entered.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.

Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Uniform Billing Revenue Code	3	Char	As defined in UB-92 manual.
Fac	Provider ID type	2	Char	FI – Federal Taxpayer's ID Number PC – Provider Commercial Number UP – Unique Physician ID Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval) COV plans to require HCFA ID if the National Provider ID is mandated for use.

Fac	Provider ID	15	Char	
Fac	Provider Name	50	Char	
Fac	Provider Type	2	Char	See attached list of valid codes.
Fac	Provider Location – City	20	Char	
Fac	Provider Location – State	2	Char	
Fac	Provider Location – Zip Code	10	Char	
Fac	Pre-Certified Admission	1	Char	"Y" : Yes "N" : No or Not Applicable
Fac	Provider In/Out Network	1	Char	"I" : Provider in Network "P" : Participating Provider not in Network "N" : Non-participating Provider
Fac	Provider Contract Level	10	Char	"HMO" "HMO POS" "EPO" "POS PPO" "PPO" "PHO" "INDEMNITY"
Fac	Total Charges	10	Amount	
Fac	Non-benefit Charges not covered	10	Amount	e.g. convenience items
Fac	Benefit Charges not covered	10	Amount	
Fac	Eligible Charge	10	Amount	Should be equal to Total Charges – Non-benefit Charges not covered – Benefit Charges not covered
Fac	Deductible	10	Amount	
Fac	Coinsurance	10	Amount	Copayment is stored in separate field
Fac	COB	10	Amount	
Fac	Facility Liability (pre-discount)	10	Amount	Amount owed facility if no discount relationship in place. Expected relationship of amounts is: Facility liability (pre-discount) + COB + Copayment + Deductible = Eligible Charge.
Fac	Facility Liability (post-discount)	10	Amount	Amount contracted with Facility.
Fac	Discount retained by carrier	10	Amount	Portion of total discount retained by carrier for ASO. Remainder of discount is assumed to be Commonwealth's, which may consist of 2 portions: a guaranteed portion which is credited immediately and a settlement amount which is credited later, usually after the close of the fiscal year.
Fac	Discount guaranteed to Commonwealth	10	Amount	Amount of discount credited to Commonwealth on initial bill
Fac	Commonwealth's settlement discount	10	Amount	Amount of discount credited (or due to be credited, if known in advance) to Commonwealth after close of fiscal year.
Fac	Net Payment After Application of Reimbursement Method	10	Amount	The expected relationship is that Net Payment After Application of Reimbursement Method = Facility Liability

				(pre-discount) – Discount guaranteed to Commonwealth – Commonwealth's Settlement Discount
Fac	Internal Claim ID	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.
Fac	Copayment	10	Amount	Copayment separate from Coinsurance
Fac	Contract Type	1	Char	Blank or 'A' – Active 'C' – Cobra 'R' - Retiree
Fac	Filler	32	Char	Spaces
	Record length	*700*		
Pharm	Record Type	1	Char	Value = 'D'
Pharm	Carrier Code	3	Char	To be defined by COV
Pharm	Covered Group	1	Char	"C" – Commonwealth of Virginia "S" – TLC School Group "G" – TLC Governmental Group
Pharm	Plan Code	4	Char	To be defined by COV
Pharm	Contract Number (Subscriber SSN)	9	Char	No '-'
Pharm	Subscriber Birth Date	8	Date	
Pharm	Subscriber Sex	1	Char	"M" : Male "F" : Female
Pharm	Subscriber Zip Code	10	Char	
Pharm	Subscriber Agency/ TLC Group	3	Char	For State, Agency Code from BES feed. If not active, COV may provide desired code(s) to denote COBRA, early Retiree, Medicare Retiree. For TLC, School or Government Group Identifier.
Pharm	Patient SSN	9	Char	Optional. No '-'.
Pharm	Patient Last Name	20	Char	
Pharm	Patient First Name	15	Char	
Pharm	Patient Birth Date	8	Date	
Pharm	Patient Relationship to Subscriber	1	Char	"E" : Self "S" : Spouse "C" : Child "O" : Other
Pharm	Patient Sex	1	Char	"M" : Male "F" : Female
Pharm	Patient Zip Code	10	Char	
Pharm	Claim Number	20	Char	
Pharm	Claim Number Suffix	2	Char	Optional. Can be used to differentiate multiple items (lines) on claim.
Pharm	Claim Incurred Date	8	Date	
Pharm	Claim Received Date	8	Date	
Pharm	Claim Adjudicated Date	8	Date	
Pharm	Claim Processed Date	8	Date	
Pharm	Claim Check Date	8	Date	Date on the check when issued.

Pharm	Claim Paid Date	8	Date	This date should be the date upon which claims are booked to your financial and accounting systems.
Pharm	Claim Disposition	1	Char	"O" : Original Claim "P" : Positive Adjustment "N" : Negative Adjustment
Pharm	Optional Benefit Utilization (Expanded Benefit)	1	Char	"Y" : Used expanded benefit "N" : Did not use expanded benefit or expanded benefit option not part of this plan design
Pharm	Optional Benefit Utilization	1	Char	Reserved for future use
Pharm	Optional Benefit Utilization	1	Char	Reserved for future use
Pharm	Claim Approved/Denied	1	Char	Space or "A" – Approved "D" – Denied (Total Charges = Not Covered Charges)
Pharm	Capitated/Non-Capitated	1	Char	Space or "N" – Non-capitated "C" - Capitated
Pharm	Claim Primary Payer	1	Char	"T" : This carrier is primary "M" : Medicare is primary "O" : Other carrier is primary
Pharm	Claim Secondary Payer	1	Char	"T" : This carrier is secondary "M" : Medicare is secondary "O" : Other carrier is secondary "N" : No secondary payer "U" : Secondary payer not verified
Pharm	Claim Tertiary Payer	1	Char	"T" : This carrier is tertiary "O" : Other carrier is tertiary "N" : No tertiary payer "U" : Tertiary payer not verified
Pharm	NDC Drug Code	11	Char	In 5-4-2 format.
Pharm	Therapeutic Class Code	2	Char	00-99 from NDDF User Manual
Pharm	Generic Drug Category	1	Char	"B" : Brand Drug with NO generic equivalent "E" : Brand Drug with generic equivalent "G" : Generic Drug
Pharm	Number Days Drug Supplied	5	Num	Signed. 0 assumed decimal places. If negative adjustment, signed negative.
Pharm	Provider ID type	2	Char	FI – Federal Taxpayer's ID Number PC – Provider Commercial Number NA – National Association of Boards of Pharmacy Number HI – HCFA National Provider ID OT – Other ID (subject to COV approval) COV plans to require HCFA ID if the National Provider ID is mandated for use.
Pharm	Provider ID	15	Char	
Pharm	Provider Name	50	Char	
Pharm	Provider Type	2	Char	See attached list of valid codes.
Pharm	Provider Location – City	20	Char	
Pharm	Provider Location – State	2	Char	

Pharm	Provider Location – Zip Code	10	Char	
Pharm	Provider In/Out Network	1	Char	"I" : Provider in Network "P" : Participating Provider not in Network "N" : Non-participating Provider
Pharm	Provider Contract Level	10	Char	"HMO" "HMO POS" "EPO" "POS PPO" "PPO" "PHO" "INDEMNITY"
Pharm	Total Charges	10	Amount	
Pharm	Non-benefit Charges not covered	10	Amount	e.g. convenience items
Pharm	Benefit Charges not covered	10	Amount	e.g. a benefit not covered by COV's plan.
Pharm	Discount	10	Amount	If Schedule of Allowance is less than Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not covered, Discount = Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered – Schedule of Allowance. Otherwise, discount is zero.
Pharm	Schedule of Allowance	10	Amount	Applicable to this procedure, provider, and to the COV.
Pharm	Eligible Charges	10	Amount	Should be lesser of Schedule of Allowance and Total Charges – Non-benefit Charges Not Covered – Benefit Charges Not Covered.
Pharm	Deductible	10	Amount	
Pharm	Coinsurance	10	Amount	Copayment is stored in separate field
Pharm	COB	10	Amount	
Pharm	Net Payment After Application of Reimbursement Method	10	Amount	Expected relationship of amounts is Net Payment After Application of Reimbursement Method + COB + Copayment + Deductible = Eligible Charge.
Pharm	Drug Acquisition Cost	10	Amount	
Pharm	Drug Dispense Fee	10	Amount	Expected relationship is Drug Acquisition Cost + Drug Dispense Fee = Eligible Charge.
Pharm	Drug Process Fee	10	Amount	
Pharm	Internal Claim ID	20	Char	Claims may be edited for having been paid on covered individuals under the correct plan of benefits. To facilitate problem resolution, you may include an internal claim ID that will be included on the edit report.

Pharm	Copayment	10	Amount	Copayment separate from Coinsurance
Pharm	Payment Tier	1	Char	Blank or 'N' – Payment Tier Not Applicable '1' – Tier 1 '2' – Tier 2 '3' – Tier 3
Pharm	Contract Type	1	Char	Blank or 'A' – Active 'C' – Cobra 'R' - Retiree
Pharm	Filler	*224*	Char	Spaces
	Record length	*700*		
Trailer	Record Type	1	Char	Value = 'Z'
Trailer	Carrier Code	3	Char	To be assigned by COV
Trailer	File type	10	Char	Value = "CLAIM"
Trailer	Lowest processing date on file	8	Date	Claim Processed Date
Trailer	Highest processing date on file	8	Date	Claim Processed Date
Trailer	Number of Professional records on file	6	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Amount of Professional Total Charges on file	12	Amount	
Trailer	Number of Facility records on file	6	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Amount of Facility Total Charges on file	12	Amount	
Trailer	Number of Pharmacy records on file	6	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Amount of Pharmacy Total Charges on file	12	Amount	
Trailer	Filler	*616*	Char	Spaces
	Record length	*700*		

Commonwealth of Virginia
Eligibility File
Data Specifications
July 1, 2003

Transmittal Frequency: **Monthly**

Medium: **(1) CDROM. ASCII data. PC formatted records, i.e. CR, LF at end of each record.**

-or-

(2) Same as (1). Data compressed with PKZIP.

-or-

(3) Same as (1) except transmitted electronically (assuming compatible hardware and software).

Data Requirements: **All dollar amounts should have leading sign, 2 decimal places and implied decimal point. Field can be zero or blank filled. E.g. a 9 byte field containing the value ($100.00) could be coded either 'bbb-10000' or '–00010000'. Positive amounts can either have '+' sign or be unsigned.**

All dates should be provided CCYYMMDD where CC denotes Century, YY denotes year, MM denotes Month, and DD denotes Day. E.g. July 11, 1946 is '19460711'. If date is Not Applicable, field should be coded '00000000'.

File will consist of 3 type records: Header, Detail, and Trailer. There will be 1 Header record as the first record on the file, 1 Trailer record at the end of the file, and Detail records between the Header and Trailer records.

The Detail Records have been designed to capture four types of eligibility based information: administrative charges under an ASO contract, premiums under an insured or HMO contract, capitation charges, and membership. Currently, the Commonwealth does not require that all this data be provided. For the Commonwealth, detail records for capitation charges should be provided, if applicable. For TLC, there should be detail records for capitation charges and membership.

The minimum requirement for membership is providing information at the contract level, i.e. the subscriber data, including the contract tier, e.g. family. If available, dependent information should also be provided for membership.

If membership is being provided at the contract level only, only 1 detail record per contract will be provided and the

information in Member ID and the following fields will not be left blank.

If membership is being provided at the member level (subscriber + dependents), then 1 detail record will be provided for each member including the subscriber. For the subscriber, the information, in Member ID and the following fields should be completed.

For charges or premiums, multiple detail records may be provided per contract. This could be necessary to differentiate charges by member, to provide capitation detail, or to differentiate types of administrative charges, e.g. charge for Medical, Charge for Dental.

Record type	Field Name	Size	Data type	Comments
Header	Record Type	1	Char	Value = 'A'
Header	Carrier Code	3	Char	To be assigned by the Commonwealth of Virginia (COV)
Header	File type	10	Char	Value = "ENROLMENT"
Header	As of Date of file	8	Date	Date for which charges apply
Header	Filler	*178*	Char	Value = Spaces
	Record length	*200*		
Detail	Record Type	1	Char	Value = 'D'
Detail	Carrier Code	3	Char	To be assigned by COV
Detail	*Covered Group*	*1*	*Char*	*"C" – Commonwealth of Virginia* *"S" – TLC School Group* *"G" – TLC Governmental Group*
Detail	*Plan Code*	*4*	*Char*	*To be defined by COV*
Detail	Category	1	Char	"M" : Medical excluding MISA & Dental. "D" : Dental "S" : MISA "P" : Drug Card *"T" : Total Plan*
Detail	Contract Number (Subscriber Social Security Number)	9	Char	No '-'
Detail	Contract Type	1	Char	"A" : Active *For TLC, groups are administering COBRA & Retiree billing, so all Contracts will be coded Active.* "C" : Cobra "R" : Early Retiree "M" : Medicare Retiree
Detail	*Subscriber Last Name*	*20*	*Char*	
Detail	*Subscriber First Name*	*15*	*Char*	
Detail	Subscriber Birth Date	8	Date	
Detail	Subscriber Sex	1	Char	"F" : Female "M": Male
Detail	Subscriber Zip Code	10	Char	
Detail	*Subscriber Membership*	*8*	*Date*	*Date Subscriber effective in this Covered*

	Effective Date			*Group/plan/tier.*
Detail	*Subscriber Termination Date*	*8*	*Date*	*Date Subscriber coverage terminated*
Detail	*Subscriber Agency/ TLC Group*	*3*	*Char*	*For State, Agency Code from BES feed. If not active, COV may provide desired code(s) to denote COBRA, early Retiree, Medicare Retiree. For TLC, School or Government Group Identifier.*
Detail	Contract Tier	1	Char	"E" : Employee Only "S" : Employee + Spouse Only "C" : Employee + Child Only "D" : Family (both spouses employees of the Commonwealth) "F" : Family *"N" : Charge not tier-based. Do not use N on Membership records.*
Detail	*Capitation Level*	*1*	*Char*	*At least 1 "T" record is required for each subscriber(or member) capitated charge. If additional detail is available, additional records "A"-"G", "O" should total to "T".* *"T" : Total for subscriber or member* *"N" : Not applicable (for Administrative Charge, Membership, and Premium Records)* *"A" : MISA* *"B" : PCP* *"C" : Outpatient Lab* *"D" : OB/GYN* *"E" : Ophthalmology* *"F" : General Surgery* *"G" : Prescription Drugs* *"O" : Other*
Detail	Feature affecting charges	1	Char	Reserved for future use.
Detail	*Record Type*	*1*	*Char*	*Space or "A" : Administrative Charge* *"C" : Capitation Charge* *"M": Membership* *"P" : Premium*
Detail	Charge	10	Amount	*Should be zero on Membership Records.*
Detail	*Member ID*	*9*	*Char*	*Required if dependent information is being transmitted, otherwise Spaces.*
Detail	*Member Birth date*	*8*	*Date*	*Required if Member ID is populated*
Detail	*Member Sex*	*1*	*Char*	*Required if Member ID is populated* *"M": Male* *"F": Female*
Detail	*Member Relationship to Subscriber*	*1*	*Char*	*Required if Member ID is populated* *"E": Subscriber* *"S": Spouse* *"C": Child* *"O": Other*
Detail	*Member Last Name*	*20*	*Char*	*Required if Member ID is populated*
Detail	*Member First Name*	*15*	*Char*	*Required if Member ID is populated*
Detail	*Member Effective Date*	*8*	*Date*	
Detail	*Member Termination Date*	*8*	*Date*	
Detail	*Filler*	*23*	*Char*	*Spaces*

	Record length	*200*		
Trailer	Record Type	1	Char	Value = 'Z'
Trailer	Carrier Code	3	Char	To be assigned by COV
Trailer	File type	10	Char	Value = "ENROLMENT"
Trailer	As of Date of file	8	Date	
Trailer	Number of Detail records on file	6	Numeric	Unsigned. Right Justify. 0 decimals.
Trailer	Total Detail Administrative $	10	Amount	
Trailer	Total Detail Premium $	10	Amount	
Trailer	Total Detail Capitation $	10	Amount	
Trailer	Filler	*142*	Char	Value = Spaces
	Record Length	*200*		

Commonwealth of Virginia
Schedule 2-1 Definitions
July 1, 2003

1. Hospital Inpatient

Hospital Inpatient Admissions are those billed by a hospital, psychiatric hospital or skilled nursing facility for services provided by the facility to patients admitted for overnight stay. Partial day hospitalization is not considered inpatient.

Skilled Nursing Facility claims are grouped together irrespective of DRG. DRG's 138, 139, 232, 234, 235, which have a principal ICD9 diagnosis code beginning with '606' or '628' are treated as Infertility and reported in the Ancillary Category. For other admissions, the entire Hospital Admission is categorized based on Diagnosis Related Group (DRG) as documented below. The carrier is required to provide either DRG codes or ICD9 diagnosis and procedure codes as part of its Hospital Inpatient claim data

If DRG data is not available or if a carrier does not utilize DRG's, then the carrier may complete this section on a best effort basis. No data from the MISA carrier is present in the experience.. .

a. Medical DRG's

009-035
043-048
064-074
078-102
121-145
172-190
202-208
235-256
271-284
294-301
316-333
346-352
366-369
376-377
385-390
395-399
403-405
409-414
416-423
444-460
463-467
469-470
473-475
487
489-490
492
505
508-511
524

b. Transplant DRG's

103
302
480-481
495
512-513
525

c. Surgical DRG's

001-008
036-042
049-063
075-077
104-114
112-120
146-171
191-201
209-234
257-270
285-293
303-315
334-345
353-365
392-394
400-402
406-408
415
424
439-443
461
468
471-472
476-479
482-486
488
491
493-494
496-504
506-507
514-520
526-527

d. Maternity DRG's

370-384
391

e. MISA DRG's

425-438
521-523

g. Rehab DRG's

462

2. Hospital Outpatient

Hospital Outpatient refers to:

- Visits billed by a facility other than a hospital, psychiatric hospital or skilled nursing facility, or

- Visits billed by a hospital, psychiatric hospital or skilled nursing facility for services provided by the facility to patients not admitted for overnight stay. Partial day hospitalization is considered outpatient.

The Commonwealth's intent is to analyze Hospital Outpatient experience using Ambulatory Patient Classsification (APC) Group Number and Ambulatory Surgical Center (ASC) Group. The claims experience, however, was developed using a different methodology.

Skilled Nursing Facility claims are grouped together irrespective of APC or Uniform Billing (UB92) data. Claims, which have a principal ICD9 diagnosis code beginning with '606' or '628', are grouped as Infertility and reported in the Ancillary Category. For other visits, the entire Hospital visit is categorized based on Uniform Billing (UB92) data. The UB92 data breaks total charges into components based on Revenue Codes. The Revenue Codes are used to categorize the entire Visit. In the following table, the order of the categories is important. As soon as any Revenue Code is found satisfying the conditions for a category, the entire visit is assigned to that category. That is, if emergency room charges are present, the entire visit is characterized as Emergency Room. If no emergency room charges are present, then the visit will be characterized as surgery if operating room or ambulatory surgery charges are present, and so on.

If UB92 data is not available or if a carrier does not utilize UB92 data, then the carrier may complete this section on a best effort basis. Experience from the MISA carrier is not included.

Description	**Revenue Codes**
a. Emergency Room	45x
c. Surgery	36x (operating room), 49x (ambulatory surgery)
c. Surgery (Lithotripsy)	79x
d. Maternity	72x
b. Medicine (Cardiology)	48x
b. Medicine (Clinic)	51x (clinic), 52x (free standing clinic)
k. Home Health/Hospice	57x (home health aide), 58x (other visits home health), 65x (hospice), 66x (respite care)
e. MISA (Psych)	90x (psychiatric/psychological treatments), 91x (psychiatric/psychological services)
f. MISA (Substance Abuse)	944 (drug), 945 (alcohol)
j. Therapy Services (Drug/Radiation)	64x (Home IV therapy), 33x (therapeutic radiology), 342 (therapeutic nuclear medicine), 351 (chemotherapy), 352 (chemotherapy), 355 (chemotherapy), 353 (radiation), 359 (radiation)
j. Therapy Services (Physical Therapy)	42x
j. Therapy Services (Other)	41x (respiratory services), 43x (occupational

	therapy), 44x (speech-language pathology), 94x (other therapeutic services, except 944 and 945)
b. Medicine (Dialysis)	80x (inpatient renal), 82x (hemodialysis - outpatient or home), 83x (peritoneal dialysis - outpatient or home), 84x (continuous ambulatory peritoneal dialysis - outpatient or home), 85x (continuous cycling peritoneal dialysis - outpatient or home), 88x (miscellaneous dialysis)
g. X-Ray/Imaging	32x (diagnostic radiology), 40x (other imaging), 34x (nuclear medicine)
g. X-Ray/Imaging (CTScan/MRI Only)	35x (CT Scan), 61x (MRI)
h. Laboratory	30x (laboratory), 31x (laboratory pathological)
i. Other Diagnostic Tests	46x (pulmonary function), 471 (diagnostic audiology), 73x (EKG/ECG), 74x (EEG), 75x (gastrointestinal), 92x (other diagnostic)
l. Other	Any unassigned UB92 codes

3. Professional Inpatient

Professional Inpatient refers to non-Hospital services provided in a hospital, psychiatric hospital or skilled nursing facility. Each service is categorized separately, using HCPCS Level I (CPT) and Level II codes, regardless of how the services may be billed.

Fertility Claims (Diagnosis 606 or 628), Experimental Treatments (CPT codes ending in 'T'), and claims by Chiropractor and Podiatrist are moved to the Ancillary Category.

If HCPCS data is not available, then the carrier may complete this section on a best effort basis. Experience from the MISA carrier is not included.

Description	**HCPCS Codes**
a. Inpatient Visits (excluding visits to a psychiatrist)	99217-99239, 99291,99292, 99295-99298,99301-99333, 99241-99275, 99356-99357, 99361-99380.
b. ER	99281-99288
c. Medicine – Physical Exams	99382-99387, 99392-99397
c. Medicine – Immunizations	90471-90749
c. Medicine – Therapeutic Infusions/Injections	90281-90399, 90780-90799
c. Medicine - Allergy Testing	95004-95078
c. Medicine - Allergy Immunotherapy	95115-95199
c. Medicine – Ophthalmology	92002-92499
c. Medicine – Otorhinolaryngology	92502-92599
c. Medicine – Dialysis	90918-90999
c. Medicine – Chemotherapy	96400-96549
c. Medicine – Cardiovascular	92950-93799
c. Medicine – Other	90700-91999 (& not assigned to other Medicine categories). 96150-96155, 99201-99215, 99354-99355, 99500-99569
d. Maternity – Normal Delivery	59400-59430,59610-59614
d. Maternity – Cesarean Delivery	59510-59525,59618-59622
d. Maternity - Non-delivery	59812-59857

Description	HCPCS Codes
d. Maternity – Anesthesia	00850,00857,00946,0955,01960-01969
d. Maternity – Newborn Care	99431-99440
d. Maternity – Well Baby Exams	99381, 99391
d. Maternity - Other	59000-59350,59866-59899
e. Surgery/Anethesia	00100-01999, 07xxx, D7xxx, 1xxxx, 2xxxx, 3xxxx, 4xxxx, 5xxxx, 6xxxx, 99100-99142 excluding procedures 00850, 00857, 00946, 00955, 1960-1969, 59xxx
f. Mental Illness – Evaluation & Management	96100-96150 or (992xx, 994xx performed by a psychiatric professional)
f. Mental Illness – Psychotherapy	90804-90857
f. Mental Illness – Other	908xx excluding 90804-90857.
g. Substance Abuse	H0001-H1005, T1006-T1012
h. Radiology	7xxxx, Rxxxx
i. Pathology	8xxxx, Pxxxx
j. Diagnostic Tests	91000-91299, 93875-94799, 95250, 95805-95999
k. Rehab	90901-90911, 96567-96999, 97001-97799, 97802-97804, 98925-98929
l. Hearing	V5008-V5299
m. Speech	V5336-V5364
n. Other	Any inpatient Level I HCPCS code not reported above or Level II HCPCS code not reported above or in Ancillary.

4. Professional Outpatient

Professional Outpatient refers to non-dental services provided outside a hospital, psychiatric hospital or skilled nursing facility setting. Each service is categorized separately, using HCPCS Level I (CPT) and Level II codes, regardless of how the services may be billed.

Claims, which have a principal ICD9 diagnosis code beginning with '606' or '628', are grouped as Infertility and reported in the Ancillary Category. Claims performed by a chiropractor or podiatrist are grouped according to the provider, not the HCPCS code. Some Retiree Drugs are paid under the Major Medical Plan under HCPCS codes '99991-99996' and are included in the Drug Category.

Experience from the MISA carrier is not included.

Description	Codes
a. Office Visits	99201-99215, 99341-99355 performed by someone other than a psychiatrist
b. Preventive	99382-99387, 99392-99397
c. Well Baby Visits	99381, 99391
d. ER	99281-99288
e. Consults	99241-99275
f. Medicine – Evaluation & Management	99217-99239, 99291-99292, 99295-99298, 99301-99333, 99356-99357, 99361-99380
f. Medicine – Immunizations	90471-90749
f. Medicine – Therapeutic Infusions/Injections	90281-90399, 90780-90799
f. Medicine – Allergy Testing	95004-95078
f. Medicine – Allergy Immunotherapy	95115-95199

Description	Codes
f. Medicine – Ophthalmology	92002-92499
f. Medicine – Otorhinolaryngology	92502-92599
f. Medicine – Dialysis	90918-90999
f. Medicine – Chemotherapy	96400-96549
f. Medicine – Cardiovascular	92950-93799
f. Medicine – Home Health	99500-99569
f. Medicine – Other	90700-91999 & not assigned to other Medicine categories.
g. Surgery/Anesthesia	00100-01999, 07xxx, D7xxx, 1xxxx, 2xxxx, 3xxxx, 4xxxx, 5xxxx, 6xxxx, 99100-99142 excluding procedures 00850, 00857, 00946, 00955, 1960-1969, 59xxx
h. Maternity – Normal Delivery	59400-59430,59610-59614
h. Maternity – Cesarean Delivery	59510-59525,59618-59622
h. Maternity - Non-delivery	59812-59857
h. Maternity – Anesthesia	00850,00857,00946,0955,01960-01969
h. Maternity – Newborn Care	99431-99440
h. Maternity - Other	59000-59350,59866-59899
i. Mental Illness – Evaluation & Management	96100-96150, 992xx-994xx (performed by psychiatric professional)
i. Mental Illness – Psychotherapy	90804-90857
i. Mental Illness – Other	90862-90899 + any additional codes if carrier is MISA provider only.
j. Substance Abuse	H0001-H1005, T1006-T1012
j. Radiology	7xxxx, Rxxxx
k. Pathology	8xxxx, Pxxxx
l. Diagnostic Tests	91000-91299, 93875-94799,95805-95999
m. Rehab	90901-90911, 96567-96999, 97001-97799, 97802-97804, 98925-98929
n. Chiropractic	Any code performed by Chiropractor
o. Podiatry	Any code performed by Podiatrist
p. Vision	V2020-V2799
q. Hearing	V5008-V5299
r. Speech	V5336-V5364
s. Other	Any outpatient Level I HCPCS code not reported above or Level II HCPCS code not reported above or in Ancillary.

5. Ancillary

Ancillary refers to non-physician procedures and services, which are characterized using Level II HCPCS codes. Some HCPCS Level II codes are included in the Professional Inpatient, Professional Outpatient, Dental and Vision Plan categories. Any remaining HCPCS Level II codes are used to categorize Ancillary as described in the table below.

Some categories have been populated using other than HCPCS Level II codes. The Infertility Category can contain claims from Hospital Inpatient, Hospital Outpatient, Professional Inpatient, and Professional Outpatient. Most of the results are from Professional Outpatient. The Experimental Coverage category is populated based on CPT codes ending in 'T'.

If HCPCS data is not available, then the carrier may complete this section on a best effort basis.

Description	HCPCS Codes
a. Ambulance/Transportation	A0021-A0999
b. Drugs Administered	Jxxxx
c. Supplies	A4000-A9999
d. DME	Bxxxx, Exxxx, Kxxxx
e. Prosthetics	Lxxxx
f. Infertility	Any claim with ICD9 diagnosis code beginning with '606' or '628'
g. Experimental Coverage	xxxxT
h. Other	Any other Level II HCPCS code not included above or in Professional Inpatient, Professional Outpatient, or Dental

6. Drugs

Prescription Drugs are categorized by the type of Pharmacy dispensing the drug:

- Retail

  Pharmacy can fulfill walk-up prescription for up to 90 days.

- Mail Order

  Pharmacy can fulfill prescriptions for 90 days by Mail Order.

Prescription Drugs are also categorized by the Brand Name/Generic nature of the drug being dispensed:

- Brand Name with No Generic Equivalent
- Brand Name with Generic Equivalent
- Generic

MM Drugs referred to drugs paid under Major Medical for Retiree Option 1, which has no drug card.

7. Dental

A claim is categorized as Dental based on any one of the following criteria:

- if the claim was coded with a CDT2 code,
- if the claim was coded as having been paid under 1 of the 4 levels of dental services as defined by the Commonwealth: Diagnostic/Preventive, Primary (consisting of maintenance, oral surgical, periodontic, and general anesthesia services), Complex Restorative, and Orthodontic,
- if the claim was coded as specific to a dental plan,
- if the service was performed by a dentist,
- if the type of service was coded as dental,
- if the HCPCS code was Dxxxx

The Dental Experience is reported in the following categories:

Description	Codes
a. Diagnostic/Preventive	Paid as a Level 1 Claim
b. Basic	Paid as a Level 2 Claim or Dental Claim coded as 07xxx or D7xxx
c. Major	Paid as a Level 3 Claim
d. Orthodontics	Paid as a Level 4 Claim
e. Other	Any dental claims not included in a-d.

DO WE HAVE ANY WRITTEN DESCRIPTION OF THE COVERED SERVICES UNDER EACH OF THE 4 LEVELS?

8. Vision Plan

The Key Advantage Vision Plan limited services to fixed payments for eye examination, eyeglass frames and lenses. Any professional outpatient HCPCS Level I codes 92002-92499 or Ancillary HCPCS Level II codes V2020-V2799 which were paid under the Expanded Benefit provisions of Key Advantage were treated as Vision Plan.